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INDEX TO VOLUME XLIV

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INDEX TO VOLUME XLIV

ORIGINAL ARTICLES

Active Serum Complement Fixation, Description and Results of a Simple Method—Dr. Michele Gerundo, Vermillion, South Dakota 153

Acute Iritis, Acute Conjunctivitis, Acute Glaucoma and Their Differential Diagnosis—A. L. Pettis, M.D., El Dorado, Kansas 78

Anesthetic, Cocaine as a Topical—Paul W. Miles, M.D., Newton, Kansas 254

Bacillary Dysentery—John B. Nanninga, M.D., Newton, Kansas..331

Bladder Ulcer—Harry W. Davis, M.D., Plains, Kansas..... 41

Doctor of Medicine and His Responsibility, The—Alfred W. Adson, M.D., Rochester, Minnesota..... 111

Erythroleukemia—Ralph H. Major, M.D., and C. J. Weber, M.D., Kansas City, Kansas 299

Eulogy to General Francis Anderson Winter—Lt. Col. Waldo B. Farnum, Winter General Hospital, Topeka, Kansas..... 181

Fecaliths and Gallstones as Cause of Intestinal Obstruction—Alfred E. Gardner, M.D., Wichita, Kansas..... 41

Fracture of Second Cervical Vertebra, An Unusual—H. D. Collins, M.D., Beloit, Kansas 253

Fundamentals of Psychiatry IV, Types and Classification of Mental Disorders—William C. Menninger, M.D., Topeka, Kansas 1

Fundamentals of Psychiatry V, The Personality, Environmental Struggle—William C. Menninger, M.D., Topeka, Kansas..... 37

Fundamentals of Psychiatry VI, The Psychosexual Development—William C. Menninger, M.D., Topeka, Kansas..... 78

Fundamentals of Psychiatry VII, The Oedipus Castration Conflict—William C. Menninger, M.D., Topeka, Kansas..... 109

Fundamentals of Psychiatry VIII, The Object Finding Phases of Development—William C. Menninger, M.D., Topeka, Kansas..151

Fundamentals of Psychiatry IX, The Theory of the Unconscious—William C. Menninger, M.D., Topeka, Kansas..... 183

Fundamentals of Psychiatry X, The Personality Structure—William C. Menninger, M.D., Topeka, Kansas..... 294

Fundamentals of Psychiatry XI, Mental Dynamisms—William C. Menninger, M.D., Topeka, Kansas 325

Fundamentals of Psychiatry XII, Psychiatric Treatment—William C. Menninger, M.D., Topeka, Kansas..... 361

Histoplasmosis, Report of a Case with Brief Review of the Literature—Ben Boltjes, M.D., Kansas City, Kansas..... 226

Infectious Mononucleosis from a Clinical Standpoint—Hughes W. Day, M.D., Kansas City, Kansas..... 148

Medical Care for the Indigent—Ralph W. Callahan, Topeka, Kansas 8

Migraine, A Review of the Current Opinion and Its Pathology and Treatment—F. A. Carmichael, M.D., St. Joseph, Missouri..333

Multiple Hepatic Abscesses in Typhoid Fever with Recovery—Ralph H. Major, M.D., Kansas City, Kansas..... 265

Platelet Counting, A Note on—J. L. Lattimore, M.D., and Lois Gnagy, M.T., Topeka, Kansas 6

Poliomyelitis, Artificial Respiration in, the Civil Air Patrol Method—Louis K Zimmer, M.D., Lawrence, Kansas..... 289

Peptic Ulcer, An Endocrine Disease—John A. Crabb, M.D., Topeka, Kansas 368

President's Address, The—Henry N. Tihen, M.D., Wichita, Kansas 145

Procurement and Assignment Service for Physicians, Dentists and Veterinarians—Responsibilities, Accomplishments and Future Problems—Harold S. Diehl, M.D., Minneapolis, Minnesota....218

Procurement and Assignment, State—Frank H. Lahey, M.D., Boston, Massachusetts 217

Psychoneurosis of War, The Treatment of—Robert P. Knight, M.D., Topeka, Kansas 257

Pseudohermaphrodite, a Case of, with Extrophic Bladder—Solomon L. Loewen, M.A., Hillsboro, Kansas, and L. Odus Rupe, M.D., Chicago, Illinois 186

Rickettsias and the Pathogenic Viruses, The—Our Present Orientation—F. A. Carmichael, M.D., St. Joseph, Missouri..... 189

"Screw Worm" Infestation of the Ear—Ralph R. Melton, M.D., and Frederick W. King, A.B., Marion, Kansas..... 401

Seriodiagnostic Tests for Syphilis 9

Serious Gunshot Wound of the Hip—Major M. E. Pusitz, Topeka, Kansas, and Lt. R. M. Taylor..... 397

Sulfonamide Therapy on the Common Cold, Effect of—Lt. A. J. Kauver and Lt. Col. Frank R. Mount, Station Hospital, Fort Riley, Kansas 290

Tannic Acid Jelly and Silver Nitrate Dressing for Wounds—Maurice A. Walker, M.D., Kansas City, Kansas..... 5

EDITORIALS

A. M. A. Calls Editors and Business Managers Meeting..... 192

American, I Am An 338

America Must Not Be Shackled..... 404

Annual Meeting, 1944 370

Annual Meeting 158

Annual Session, The 84th 116

Annual Session 45

Army's Health, The Present State of..... 370

Blue Cross, The 338

Crile, Dr. George W., and Dr. Howard A. Kelly..... 11

Death of Twelfth District Councilor 45

Doctor Problems 404

George M. Gray Injured 298

Kansas Maternal and Infant Care Plan for Service Men's Dependents 193

Kansas Military Honor Roll 263

Kansas Quota, The 263

Kansas Society to Hold 1944 Session..... 404

Medical Care Plans 46

Medical Society Prepayment Plans..... 83

Mobilizing Our Hospitals..... 405

"More Medical Officers Needed at Once" 12

M. V.'s 46

Narcotics in Kansas Hospitals 262

Osteopaths and Doctors 82

Osteopathic Situation in Kansas, The 82

Poliomyelitis Epidemic in Kansas, The..... 264

President-Elect, The 158

President, The New 117, 158

President, The Retiring 116

Possible Solution, A 12

Rational Rationing 371

Total Bureaucracy for Medicine 298

Virus Pneumonias 158

Victory Nurses 84

War Effort in Kansas, The..... 231

War Participation Plan 11

Women's Field Army for Control of Cancer..... 117

CATALOGUED

STON MEDICAL

DEATH NOTICES

Atkins, Herbert, M.D., Pratt 163
Ball, Orrie Hugh, M.D., Dennis 382
Berger, Alexander J., M.D., Parsons 382
Bishop, Walter D., M.D., Kansas City 202
Boyce, Shirley Francis, M.D., Hugoton 100
Brown, Thomas Oscar, M.D., Osage City 414
Cabbell, Herbert G., M.D., Lawrence 62
Carter, William Henry, M.D., Wichita 100
Caswell, Charles Edmund, M.D., Wichita 322
Collins, David W., M.D., Effingham 100
Cox, Omar L., M.D., Iola 356
Daniels, Herman P., M.D., Wichita 202
Davis, Edward Gates, M.D., Kansas City 382
Dillingham, William Roy, M.D., Wichita 202
Fowler, Luther W., M.D., El Dorado 384
Gilley, Henry Walter, M.D., Ottawa 30
Ham, William Emmett, M.D., Beattie 356
Hill, Emma L., M.D., Oswego 202
Henderson, Archibald Grant, M.D., Leonardville 164
Longenecker, Oscar M., M.D., Kansas City 100
Iliff, Winfred H. (Fred), M.D., Baxter Springs 164
Marshall, Albert Henry, M.D., Topeka 322
Matassarin, Leon, M.D., Leavenworth 30
Montgomery, J. Carroll, M.D., Topeka 102
Morton, Robert J., M.D., Clay Center 414
McDonald, Smith Forrest, M.D., Severy 30
Neinstedt, William Fredrick, M.D., Hartford 322
Nelson, Charles R., M.D., Jamestown 382
Parrish, Merle, M.D., Kansas City 30
Porter, George Franklin, M.D., Centerville 30
Rea, Walton H., M. D., Arkansas City 204
Riley, Brette Redpath, M.D., Benedict 322
Shelly, Solomon Thos, M.D., Mulvane 62
Speirs, Geo. W., M.D., Spearville 62
Stillman, Charles C., M.D., Morganville 102
Tilden, Leslie Chapman, M.D., Oberlin 204
Weidling, Walter H., M.D., Topeka 64
Wickersham, Enoch C., M.D., Independence 64
Zerzan, George F., M.D., Salina 164

SPECIAL ARTICLES

AMA House of Delegates Meeting June 7 48
AMA Meeting 118, 194
AMA Meeting Exhibits 412
AMA 1944 Annual Meeting 375
American Pharmaceutical Association Gives Three Tons of Quinine to the Armed Forces 416
An Important Communication from Office of Censorship 418
Annual Re-Registration 195
Annual Session, 84th 48
Appointment 344, 410
Appointment to Board of Regents 161
Aviation Medical Examiners 196
Board of Health Appointments 161
Blast at Health Plan 344
Board Meeting 16
Blind Program 53, 198, 379
Cancer Statistics in Kansas 274
Carrying the Torch for Serice Men 314
Changes in Military Honor Roll 310
Civilian Defense 20
Clinical Society Meetings 306
Colorado Loses Executive Secretary 52
Committee Meeting 409
Commenting on the Wagner Bill 316
Commissions to Women Doctors 242
Compensation for Eye Injuries 268
Congress on Medical Education and Licensure 48
Council Meeting 16
Councilor Announcement 118
Course on Medical Protozoology for Laboratory Technicians 344
Criticism of Blue Cross Editorial 380
Defense Board Member Appointed 161
Delegates to State Meeting 118
Doctors at War 16
Dr. Hassig Honored 88
Dr. Verne C. Hunt, Shot 412
Dues, 1943 16
Federal-State Civilian Rehabilitation Program 346
Flight Surgeons 51
Food for Overseas Forces 416
Gas Defense Program 94
Gas Specialists 58
General Practice Clinics 379
Graduate Nurse Survey 92
Golden-Belt Meeting 16, 118
Hard of Hearing Week 346
Hospital Train 376
House Bill No. 40 48
Industrial Health Institute 161
Invalid Diets and Rationing 118
Joint Committee Meetings 16
Joint Meeting 240
Journal Desk 52, 94, 122, 198, 240
Kansas Accidental Death Report 379
K.C.U. of Physicians and Surgeons to Close 410
Kansas Doctors of Medicine Honored 409
Kansas Doctor Shortage 412
Kansas Hospital Association Meeting 90
Kansas Maternal and Infant Care Plan Progresses 267
Kansas Obstetric and Gynecological Society Meeting 118
Kansas Pre-Natal Law 310

Kansas Population Increases 380
Kansas Tuberculosis Meeting 350
Kansas X-Ray Technicians Society Approved 412
Lecture 376
Legislative Bills 94
Legislation 14
Legislative Measures 48, 90
Maternal and Infant Care 238
Major Dixon Returns to Topeka 90
Medical Board Meetings 346
Medical Motion Pictures 380
Medical Practice Violator 18
Meeting 161, 376
Military Surgeons Meeting 314
Minutes 30
Narcotics in Hospitals 240
Narcotic Permits 195
Narcotic Prescriptions 53
New 1943 Army Quota 86
New Attorney 16
New Children's Hospital in Mexico City 350
New Committee Chairman 16
New Committees 235
New Director of Venereal Disease 18
New Doctors of Medicine 242
New Editorial Board Members 161
New Fee Schedule for Maternal and Infant Care Plan 346
New Members CMAB Advisory Committee 346
New Publication 20
New Red Cross Director 90
New Roster for Kansas Physicians 268
New Quarterly Review of Obstetrics and Gynecology 198
Nurse's Aides for Veterans' Hospitals 56
NYA Gives Health Report 22
OCD Blood Plasma Reserve 94
Offers Suggestions for Limiting Spread of Infantile Paralysis 268
Orthopedic Surgeons Meet 18
Osteopathic Brochure 51
Osteopaths 350
Outline of Plan, Material and Infant Care 196
Physicians Tour Plant 92
Physicians Wanted 118
Plasma for Civilian Defense 56
Plastics in Advertising 312
Porter Lectureship 414
Post Graduate Course 161
Post Graduate Courses in Disease of the Chest 316
Post Graduate Course in Tropical Medicine 238
Post Graduate Course in Disease of the Lungs 267
Preparations in Treatment of Malaria 20
Procurement and Assignment Survey 375
Procurement Quota 306
Purpose of Council on Medical Service and Publications of AMA 410
Questions on Maternal and Infant Care Plan 377
Rationing for Patients 418
Resolution Passed by Nurses Association 376
Resignation 414
Reviewing the Activities of Kansas Medicine 1942-1943 276
Rhode Island Journal 352
Secrtaries and Editors Meeting 346, 376
State Meeting 86
Tropical Medicine Lecture 346
Tularemia Hazards 350
Victory Book Campaign 53
War Gas 24
War Medicine Becomes a Monthly 53
War Session Meeting April First 88
Winter General Hospital 195
Women Doctors in the Navy 390
Women Medical Corps Captain to Fort Riley 348
Workmen's Compensation Fee Schedule 53
Wyandotte County News Letter 90

ANNOUNCEMENTS

32, 104, 176, 246.

COUNTY SOCIETIES

26, 60, 98, 163, 198, 354, 414.

KANSAS MEDICAL AUXILIARY

36, 72, 108, 144, 180, 216, 252, 288, 324, 360, 428.

BOOKS

32-34, 66-68, 104, 248, 284-286, 422-424.

MEMBERS

28, 58, 102, 162, 200, 320, 352, 414.

MEN IN SERVICE

302-304, 342-344, 374-375, 408-409.

OFFICIAL PROCEEDINGS

119-138, 164-176, 204-214.

KANSAS MEDICAL ASSISTANTS SOCIETY

70, 106, 142, 178, 250, 358, 426.

PRESIDENT'S PAGE

10, 44, 81, 115, 157, 191, 230, 262, 297, 337, 369, 403.

TUBERCULOSIS CONTROL

12, 46, 85, 159, 266, 301, 339, 372, 406.

KANSAS MILITARY HONOR ROLL

232-234, 310.

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FUNDAMENTALS OF PSYCHIATRY IV

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TYPES AND CLASSIFICATION OF MENTAL DISORDERS

The psychiatric point of view includes an attempt to understand the motives of all human behavior, normal and abnormal, in health and in disease. The practice of the psychiatrist and the psychiatric nurse, however, is limited to those illnesses of mankind characterized by marked (and often persistent) abnormal feelings or thoughts or behavior. In beginning a study of this relatively limited field, the student must become acquainted with the structure and dynamic expressions of the personality. However, to make such an approach more helpful and understandable, it is desirable and, in fact, almost necessary for the student to know some general concepts of the types and classifications of mental illness. Not only does the early orientation within the field of psychiatry help one better to understand the mental machinery, but it also serves to introduce some of the technical terms of psychiatry and an understanding of them.

MAJOR GROUPS OF MENTAL DISORDERS

To those mental disorders which are expressed in a severe form the psychiatrist gives a name to each particular reaction type—a diagnosis. To the minor disabilities which all of us experience he doesn't attempt to give a name. Limiting the discussion to those disorders for which he does make a diagnosis, we can classify all of these into three large general groups—the psychotic reactions, the neurotic reactions, and the characterologic defect reactions.

Psychotic reactions:—A psychotic reaction refers to those more severe illnesses characterized by a distortion or disorganization of the personality, in which the individual fails to recognize the real causes for his illness, and frequently even denies that he has an illness. In a psychotic reaction the patient falsifies the facts of the external world of reality, or his status in it, or both. He cannot accept the realities of life, and so he must change them, by additions, by distortions, or by denials. The psychiatrist applies technical names to the various ways in which the individual changes his conception of the outside world. He may develop delusions which are false beliefs which become fixed and are not amenable to reason. For instance, an individual may believe that he is a King, or that the Ku Klux Klan is after him, or that the doctor or nurse is an enemy who is attempting to undermine his reputation. Another form of reality falsification is the hallucination which is a false perception without external stimulus. The patient may have a visual hallucination, i.e., a vision of angels, of God, or of the devil. He reports seeing things which no one else sees; he may hear voices, or taste poison in his food, or smell obnoxious odors, or feel electricity playing on his body—none of which are in keeping with his real situation of life. Still another form of denying reality is illusions, which are misinterpreted perceptions which are not amenable to reason. All of us are familiar with the so-called optical illusions, or mirage, of camouflage as used in the war, or of the childhood experiences of hearing noises on the stairs at night, but all of these are amenable to reason and the term illusion as used by the psychiatrist does not apply to them. In illusions as expressed by mentally sick people, a patient may believe a nurse to be a relative; another patient's voice may be the disguised voice of a former friend; a passing car may be thought to be filled with police officers.

This group of illnesses known as the psychoses includes a wide variety of mental pictures, including the deliriums, the mental illnesses caused by physical agents or poisons or infections, and the large group of illnesses called functional psychoses for the reason that no physical causes or pathological changes in the tissues can be demonstrated to be present.

Neurotic reactions:—This group of illnesses is characterized by a great variety of symptoms in which the individual appears to involve only himself without the necessity of falsifying facts or realities in the external world. In the psychoses, we have seen how the individual's conflict makes it necessary for him to misrepresent facts or factors in the external environment, whereas in neurotic reactions

the individual's personality remains relatively intact and he does not use such methods as the formation of delusions or hallucinations or illusions.

A conflict is present in both psychotic and neurotic reactions. In a psychotic reaction the personality tries to ignore this conflict by changing things to fit his needs, whether these changes are in keeping with the facts or not. In the neurotic reaction the individual doesn't go quite so far; he makes a compromise between himself and the demands of the world and his symptoms are an expression of this compromise. Because of forces within himself as well as forces in the external world, his unconscious forbidden wishes can gain expression only in the form of a symptom. Thus the symptom gives him a kind of gratification (even though it is grossly distorted from what we consider normal gratification) and at the same time serves as punishment to him (in the pain or fear or anxiety) because he is expressing a forbidden wish.

These compromise reactions take many forms. Through unconscious motivation a thought process (the wish) may take the form of a physical symptom which is then known technically as a conversion symptom. The idea is not permitted to be expressed directly and is changed to a physical sign or symptom and thus expressed indirectly. Such a symptom is illustrated by hysterical paralysis where there is nothing wrong with the nerves or the muscles or the bones and yet the individual is not able to move his arm; or in aphonia, a condition in which the individual suddenly loses his voice for a few hours or days, and then as suddenly it returns. Obsessions are another form of compromise reaction in which an idea or a set of ideas persistently recurs or remains fixed against one's will. Often such ideas are associated with the necessity for carrying them out or warding them off—compulsions. Thus, an individual may have the obsession that the number "9" is unlucky and of ominous import to him, with the resulting compulsion that he can do nothing on any date which has a nine in it, can buy no article which has a nine in the price, can have no part in a party of nine people, etc. Phobias or morbid fears represent another compromise reaction, in which the individual may be so afraid of contracting tuberculosis that she can wear her clothes only after they have been washed in Lysol, her dishes must be scalded after each using, she cannot tolerate the sight of anyone touching her food, her linen must be clean each night. Or the phobia may take the form of a fear of high places, or of crowds, or of animals, or of contracting syphilis, or of dirt, or a host of others.

There are many other forms of compromise reactions in the neurotic individual. It is important, however, to recognize that even in the presence of such symptoms the individual's personality does not become disorganized. He is not "crazy" in any sense of the word as used by the layman. In the majority of instances he recognizes the lack of any adequate explanation for his symptoms; he recognizes them as being senseless, irrational and unjustified, and yet he cannot do away with them or stop them.

Characterological Defect Reactions:—This group of mental disorders is characterized by the absence of awareness on the part of the patient of any conflict or distress. These individuals would never admit that they are either sick or "abnormal." The illness exhibits itself largely in antisocial or unconventional behavior, and usually the patient is quite free from any "symptoms." This group includes the sexual perverts; the individuals who are always colliding with society but never seem to know it; criminals; and the infantile characters.

The Limitations of These Groupings:—Even though these three groups are very large, and their definitions seem quite clear-cut, the psychiatrist recognizes the arbitrary nature of this or any kind of a grouping, and the very thin line of demarcation that separates one group from another. Thus, we may find vague physical complaints in both neuroses and psychoses. It is often extremely difficult to differentiate between a severe obsessional nurosis and a schizophrenic psychosis. As was stated above, these groups do not include the greater part of psychopathology that can be observed in the everyday life of the average person. All too often, it is assumed that such groupings are inclusive, that is, that they include every type of abnormal mental reaction; they include only the more exaggerated types of reaction —the individuals who because of the acuteness of their disturbances, or the chronicity of their maladjustments are totally incapacitated to play the game of life happily, and efficiently, and compatibly with their fellow players.

CLASSIFICATION OF MENTAL DISORDERS

In every field of science the worker has the task of accumulating his data, of studying and observing it, and then attempting to classify it. Psychiatry as a branch of science has attempted many times to do this (and undoubtedly will continue to do so) with the result that there have been a great many classifications of mental disorders. The first outstanding effort was made in 1780 by Cullen who arranged a comprehensive system based on the irritability of tissue. He was followed by Pinel in 1809 with his "nosographis methodica," and Wilhelm Griesinger in 1845 who attempted a systematic arrangement of mental disorders on the basis of symptomatology. On the basis of his description of various clinical

pictures, Kraepelin achieved the greatest distinction with his detailed classification worked out between 1880 and 1910. In 1918, Southard proposed a grouping of mental illnesses into twelve types on the basis of their etiology. In 1919 Kempf proposed an "autonomic-affective" grouping. Between 1920 and 1935 there have been several attempts by the psychoanalytic group to classify the neuroses and Glover included the psychoses also. The "standard" classification now used in most mental institutions was last revised by a committee from the American Phychiatric Association in 1934.

There is a widely held opinion, however, among most psychiatrists that none of our classifications, even the present one, is at all satisfactory. Even the student may see that in one instance the name of a disease is based on the causation of the illness; in another on the organic description; in another, a description of the mental symptoms; and still another on a basis of the dynamic understanding of the illness. As a result we have at present a conglomerate classification with a mixture of terms designating historical, yhysiological, organic, descriptive, and psychogenic influences in their choice. The fact that it has been so inadequate has led various psychiatrists from time to time to attempt to make a classification of personality reactions according to types, rather than specific disease entities. The result has been Bleuler's schizoid and syntonic types, Kretschmer's athletic, asthenic, pyknic, and dysplastic types, Jung's introvertive and extravertive types, Adolf Meyer's seven mental disease reaction types (organic, delirious, paranoid, affective, schizophrenic, primary constitutional, and psychogenic.)

In addition to the fact that the present classification and nomenclature of mental disorders are based on various approaches (descriptive, etiologic, physiologic, organic) there are other difficulties in making a diagnosis. In actual practice one sees many instances in which the symptoms suggest two or more diagnoses and the case defies any single diagnosis. One may say that definitely circumscribed clinical entities are rare. Even more important is the fact that knowing the diagnosis of a case does not necessarily indicate much. Many persons know the name of a disease, for instance, dementia praecox, and hold the belief that because they have seen one or a dozen cases they know the disease, and yet have no real understanding of the nature or psychologic significance of the illness. It is far more important to understand a patient's conflict and what the symptoms mean with reference to the conflict, than to be able to give the illness a name—a diagnosis.

The fact remains that every psychiatrist does make diagnoses, and uses a classification even though he may modify it to suit his own point of view. Some form of systematic grouping is almost a necessity even though it has defects. A diagnosis has the practical advantage of being a handle for a general concept, which permits the interchange of ideas between two or more psychiatrists; it serves as a title for a chapter in a text; it permits the scientist to group illnesses which have certain characteristics in common; and it serves as the basis for classification which is essential in some forms of research.

CONDENSED OUTLINE OF MENTAL DISORDERS

For the orientation of the reader a bird's-eye view of the various clinical pictures or "diagnoses" of the different types of mental disorders is given below. The classification used here is modified only slightly from the "standard" form used and approved by the American Psychiatric Association.

I PSYCHOTIC REACTIONS:—Severe mental illnesses characterized by distortion or disorganization of the personality, with the loss of understanding of the illness and with the development of various forms of reality falsification.

A. FUNCTIONAL PSYCHOSES:—A group of mental illnesses in which no physical causes or pathology can be demonstrated.

1. Manic-Depressive Psychoses: A group which in one phase is characterized by an excitement and over-activity, and in another phase, by depression and under-activity; there is a tendency to an alternation or a mixing of these two phases.

2. Schizophrenic Psychoses (Dementia praecox): —A group of illnesses characterized by affective and intellectual disorders in varying degrees and mixtures, which a tendency to retreat from reality, the expression of emotional disharmony, and a tendency to "deterioration."

3. Paranoia and Paranoid States:—A group of illnesses characterized by a delusional system of jealousy, ideas of reference, delusions of persecution, or delusions of grandeur.

B. ORGANIC PSYCHOSES: Psychotic reactions which are the secondary expression of localized or generalized brain damage.

1. Psychoses Due to Brain Infections:—The most important diseases in this group are syphilis of the brain (general paralysis) and epidemic encephalitis.

2. Psychoses Due to Senile and Arteriosclerotic Brain Changes:—A group of psychoses occurring in advanced age, sometimes due to cellular atrophy of the brain tissue, sometimes to arteriosclerosis in the brain, and often with the two conditions associated.

3. Psychoses Due to Exogenous Posions:—The most important agents are alcohol, drugs, heavy metals, and carbon monoxide.

4. Psychoses Due to Endogenous Toxins:—The reactions result from the toxins arising from generalized infections in cardiorenal disease, in exhaustion, and in pregnancy.

5. Psychoses with Systemic Disease:—This group includes various diseases in which the central nervous system is affected, i.e., pernicious anemia, and pellagra, as well as mental disorders associated with other physical disease, i.e., with disorders of the endocrine glands, with cancer or organs other than those of the brain or spinal cord.

6. Psychoses with Epilepsy:—Altho relatively infrequent, psychotic mental reactions occur in some long standing cases of epilepsy.

7. Psychoses with Brain Tumor:—Psychoses may result from generalized intracranial pressure or may result as a focal symptom due to damage to or destruction of a certain area in the brain.

8. Psychoses with Trauma:—A psychosis may develop as a delirium immediately following an injury to the head, it may develop as a chronic confusion some time after trauma in a predisposed individual; and occasionally mental reaction may eventuate in progressive mental enfeeblement.

II. NEUROTIC REACTIONS:—A group of mental illnesses characterized by a great variety of mental or physical symptoms, or both, in which the personality is not grossly disorganized and does not falsify or distort the external reality situation.

A. Neurasthenia:—An illness characterized chiefly by many physical complaints and symptoms without the physician being able to demonstrate any change either in the function or structure of the organ or organs.

B. Anxiety Neurosis:—A neurotic reaction characterized by a "free-floating" anxiety, not consistently referred to or attached to any specific stimulus or object, and accompanied by various physical manifestations of fear.

C. Hysteria:—This group includes the sub-groups of (1) anxiety hysteria characterized by the formation of phobias (of tuberculosis, of cancer, of closed places) and (2) of conversion hysteria characterized by the development of various physical symptoms (paralysis, anesthesia, epileptiform convulsions, blindness, etc.)

D. The Compulsion and Obsessional Neuroses:—A group of reactions characterized by fixed, but recognizedly irrational ideas (obsessions) and the action out of these ideas (compulsions), both of which are so bizarre as to interfere with leading a normal life and forming normal relationships.

III. CHARACTEROLOGIC DEFECT REACTIONS:—A group of individuals whose maladjustments are exhibited chiefly thru antisocial or unconventional behavior, and who are usually free from symptoms and not aware of any conflicts or mental distress.

A. Perversions:—A group of individuals who find their sexual gratification in forms other than normal heterosexual relations.

B. Neurotic and Psychotic Characters:—This type of reaction is often described as the psychopathic personality, a disorder in which the individual's particular behavior and acts are substitutes for neurotic symptoms. The individual acts out in his total life situation aggressive impulses which are either antisocial or unproductive, or both.

C. Criminality:—A group of reactions characterized by antisocial behavior toward society which may be the result of specific situations, of organic defects, of social training, or of a neurotic need for punishment.

D. Feeblemindedness:—A type of organic defect characterized by an arrest or retardation of the mental development, primarily of the intelligence, but accompanied by a defect of judgment, social inadequacy, and emotional instability.

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9. Wechsler, I. S.: The Neuroses, Phila., W. B. Saunders Co., 1929, Pp. 121-147.

Specialists Outnumber General Practitioners—As of January 31, 1942, 85,964 of these were in general practice and 90,227 specialists (including those classified as fully qualified specialists devoting their full time to a specialty and physicians who devote only special attention or a part of their time to some special branch of medicine). The ratio of full-time specialists to special attention physicians is about forty-three to fifty-seven.

The total number of physicians engaged in full-time appointments was found to be 7,216. Of these, 2,816 hold teaching appointments, 910 are engaged in full-time research work, 1,179 hold executive positions and 2,243 are engaged in full-time work in industry. Many of the latter are not actually caring for the sick or injured though they are contributing to the health of the industrial population. —Minnesota Medicine.

TANNIC ACID JELLY AND SILVER NITRATE DRESSING FOR WOUNDS

Maurice A. Walker, M.D.*

Kansas City, Kansas

Dressings are applied to clean wounds to aid in controlling bleeding, to prevent contamination and subsequent infection, to serve as splints, and for their esthetic appearance. A natural dressing for wounds is the scab formed by coagulation and drying of blood and tissue fluids. In a variety of wounds to be reported in this paper a method is described for rapidly producing a tough firm smooth black scab that remains intact for a week or ten days, and fulfills satisfactorily the requiremens of hemostasis, antisepsis, protection, splinting, and appearance. This type of dressing is inexpensive, easy to apply, and may be reinforced by subsequent applications if necessary. It is particularly useful in sites where gauze is held in place with difficulty. Finally, its use will greatly decrease the need for gauze and adhesive tape.

CASE REPORTS

Case 1. A girl, aged twenty-two, was thrown from a moving automobile when she chose to walk home. There were extensive superficial abrasions ("brush burns") of her right shoulder and her entire back. After washing gently with soap and water for ten minutes and rinsing with sterile saline solution, tannic acid jelly was spread lightly over the abraded areas. Solution of ten per cent silver nitrate was painted over the jelly with applicators. A dense shiny black eschar formed immediately and was dry within fifteen minutes. All pain ceased. When the eschar gradually separated ten to fourteen days later the abrasions had been completely covered with epithelium.

Case 2. A woman, aged thirty-two, tripped as she was going upstairs and scraped a considerable amount of skin off her shin. She came to the physician two days later because this abraded area was painful, especially after the gauze dressings that she had applied became adherent and pulled on the underlying raw tissues. These dressings were removed after soaking with hydrogen peroxide. Tannic acid jelly was applied and then solution of ten per cent silver nitrate. No other dressing was needed after the eschar dried. She was even able to wear her hose directly over this smooth firm film.

Case 3. A boy, aged three, fell against a toy. A vertical lacerated wound one inch long was made through the right eyebrow. After cleansing this region, a silk suture was used to draw the skin together. Tannic acid jelly was applied to the wound. After a few minutes the excess was removed and solution of ten per cent silver nitrate applied. The film that resulted was an entirely satisfactory dressing. Gauze would have been difficult to apply in this location and hard to keep in place on a child. A week later the film was freed around its edges and gently lifted. The knot and ends of the suture were adherent in the film so that the suture could be easily cut and removed.

Case 4. A man, aged twenty-three, received a straight incised knife wound two inches long across his check in a fight. About one hour later the wound was cleansed with soap and water and its edges brought together with three silk sutures. Tannic acid jelly was applied along the cut. The excess was wiped off after a few minutes and solution of ten per cent silver nitrate applied. A black shiny film one-fourth inch wide was deposited, completely protecting the wound and sutures. He was able to continue at his usual work as a railroad switchman. Most of his associates thought he merely had a smudge of dirt on his face. A bandage or dressing in this location would have been difficult to hold in position, would have obscured his vision, and would have been so conspicuous that he would not have been allowed to continue at work.

Case 5. A salesman, aged twenty-five, was seen about twenty minutes after he had permitted a firecracker to explode in his right hand. Painful abrasions and excoriations of the thumb and index finger had resulted. Antitetanic serum was administered. After cleansing with soap and running water, tannic acid jelly was applied to the injured area. The pain was immediately diminished. A few minutes later, when a gray coagulum had appeared, the excess of jelly was gently removed with gauze. The thumb and finger were then painted with solution of ten per cent silver nitrate. A shiny black film formed, becoming dry and tough in about fifteen minutes. No other dressing was necessary. Although his thumb and finger were rather stiff, he was able to write and do his usual work, which he could not have done if a bulky dressing had been applied. Healing occurred without infection.

Case 6. A man, aged fifty-five, was hit on the side of the head by a steel bar. The helix of the ear was torn entirely through in a straight line. After cleasing the wound with soap and water, through and through sutures of silk were used to hold the flaps together. Tannic acid jelly was applied to both sides of the ear. After a few minutes a solution of ten per cent silver nitrate was applid. The resulting black

*Major, Medical Corps, United States Army.

tough film acted as a rigid splint. No other dressing was needed. Perfect healing resulted.

Case 7. A woman, aged forty-two, had three wens in her scalp varying from one-half to one inch in diameter. The hair around each was trimmed, an antiseptic applied, and solution of one per cent procaine hydrochloride infiltrated. Each cyst was easily removed intact through a straight incision. A silk suture was used to close each wound. Tannic acid jelly was applied for a few minutes, the excess removed, and solution of ten per cent silver nitrate applied. A firm black film formed over each wound making an entirely satisfactory dressing. The films were pulled off a week later and the sutures removed.

Case 8. A man, aged thirty, dropped a heavy weight on his right great toe. When seen two days later the entire nail was loosened by a subungual hematoma, and was easily removed. The nail bed was sponged dry and coated with tannic acid jelly. This stopped all bleeding. After a few minutes the excess was wiped off and solution of ten per cent silver nitrate applied. A tough black film formed and dried within fifteen minutes, furnishing a satisfactory dressing for the raw area. He was able to continue at his usual work.

The recent Conference on Medical-Service Plans, held in Chicago under the auspices of the American Medical Association, gives evidence of the nation-wide interest in this movement. Sixty-four persons attended, including representatives from operating and proposed medical-service plans in seventeen states. As Dr. Olin West stated in his opening address, the conference was called to exchange information and opinions and thus to obtain an understanding of the basic problems.

The development of prepayment medical-service plans has chiefly involved three types of organization: the group clinic or consumer group, of which there are seventeen in operation, with a total enrollment of 100,000 persons; the employee-employer mutual-benefit association, of which there are about three hundred, and the commercial insurance company, with about two hundred and fifty plans, all of which provide cash indemnity benefits of $365,000,000 annually; and the nonprofit medical-service plans sponsored by medical societies of which thirty-three are operating in nine states, with an enrollment of about 750,000 persons. Within the last few years, the last type has developed rapidly and apears to offer the best means for a proper distribution of medical service.—New England Journal of Medicine.

There can be no such thing as chronic pulmonary tuberculosis without a first infection. However, it is not usually the first infection that is important—what matters most is the subsequent superinfections and reinfections which should be guarded against in the infected group.—David Zachs, M.D., Jour. of School Health.

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A NOTE ON PLATELET COUNTING

J. L. Lattimore, M.D.

Lois Gnagy, M.T.*

Topeka, Kansas

Platelets, owing to their small and variable size, their tendency to adhere to foreign bodies or to each other, and their predilection for disintegrating rapidly, have always been difficult to count with anything approaching absolute accuracy. We had been dissatisfied with our routine method for some time, and after a preliminary review of the literature, chose four methods for study. This was not an attempt to originate or to make an exhaustive investigation of any one method. The sole purpose was to compare several existing methods in the hope of finding one which the average busy hospital laboratory technician could do quickly, with the materials at hand, and that would give a report which she could feel confident was well within the limits of clinical significance.

With this purpose in mind we chose the Fonio indirect smear method, a centrifuge method by Vilarino and Pimentel, its modification by Copley and Robb (these latter reported by Alfred L. Copley and Thomas P. Robb in the American Journal of Clinical Pathology, 12:362-371, for July 1942, under the title "Studies on Platelets. I. The Method of Vilarino and Pimentel, and a New Direct Method of Counting Blood Platelets."), and, fourth, the direct hemocytometer method using the Rees-Ecker diluent.

A preliminary series of counts was made in order to become familiar with and to acquire the necessary skill for making counts by each of the chosen methods. Following this, a series of blood specimens were counted, each specimen counted by each of the four methods, in duplicate, which meant in reality eight platelet counts for each specimen. The Fonio indirect smear method proved to be grossly inaccurate, duplicate counts on the same specimen often varying by as much as one hundred thousand. Counts made by each of the other three methods gave mutually comparable and reproducible results quite consistently.

Assuming, then, that counts made by any one of these three methods would give a reasonably dependable platelet count, it remained to choose one which would be most practical for routine use. The chief objection to the Vilarino and Pimentel, and to the Copley and Robb methods was the necessity for

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obtaining the blood specimen by venipuncture, using a two cc. syringe which already contained one cc. of a formalin diluting solution. Adding to this the repeated washing and centrifuging required by the Vilarino and Pimentel method, and the several dilutions involved in the Copley and Robb method, we felt that the results obtained were not sufficiently superior to justify the extra time and materials required.

This left the Rees-Ecker count as the most likely to fill our need. The remainder of the investigation was confined to a series of counts made in duplicate by this method. We found that once thoroughly familiar with the method, we obtained counts which consistently checked on any one specimen within thirty thousand. Our normals by this method fell between one hundred and seventy-five and two hundred and fifty thousand.

It might be well to mention here a few points of technique. We made our Rees-Ecker diluting fluid as directed by Kolmer and Boerner in the second edition of their Approved Laboratory Technique, using 100 mg. of brilliant cresyl blue in 100 cc. of a 3.8 per cent sodium citrate solution, and adding 0.2 cc. of formalin. The directions given include filtering each day before using, and we found that this was necessary, since some platelets are not very much larger then granules of precipitated or undissolved stain which might be found in the unfiltered solution.

We also found that while the directions state that the diluting fluid should be drawn into a red-blood diluting pipette nearly to the one mark, then blood from a freely flowing puncture to exactly 0.5, it was difficult to measure the blood accurately when a column of diluting fluid remained in the bore of the pipette. It proved easier to draw the short column of diluting fluid on into the bulb of the pipette before drawing in and measuring the blood. The thin film of diluting fluid which did remain in the bore of the pipette gave a minimum of difficulty and yet seemed sufficient to prevent any appreciable clumping of the platelets before the remainder of the diluting fluid could be drawn in and mixed with the blood.

After thoroughly shaking the filled pipette, we filled the counting chamber as usual for an erythrocyte count. We found that it was necessary to allow the solution to stand in the chamber the full ten minutes recommended. Counts made after only five minutes were as much as seventy-five thousand lower than those made after ten minutes.

Some difficulty in recognizing platelets was encountered at first. With this fluid the platelets appear as filmy, pale blue, refractile, motile oval bodies, from one-fifth to one-half the size of red cells. A few red cells do take the blue stain, but they are quite easily recognized by their size.

Of the twenty rows of twenty squares each which make up the central area of the Neubauer counting chamber, the second and third rows of each of the five sections are bounded top and bottom by single rather than triple lines. We counted the platelets in the two hundred small squares which make up these ten single-lined rows. The number of platelets counted in these two hundred squares multiplied by four thousand gives the platelet count per cubic millimeter of blood.

At the close of our study we felt that the direct hemocytometer method, using the Rees-Ecker diluting fluid, was a satisfactory method for routine counting of blood platelets.

A near relative of sulfadiazine has been prepared by Imperial Chemical (Pharmaceuticals) Ltd., termed sulfamethazine. This compound has the advantage over sulfadiazine of being highly soluble, so that a concentrated preparation (1 Gm. in 3 cc.) can be given intravenously where required, while the risk of renal damage from insoluble crystals is probably obviated.

This new drug has been tested on a series of seventy-three patients with lobar pneumonia and in a few cases of meningococcal meningitis and acute gonorrhea. For pneumonia therapy an initial dose of four Gm. was given followed by two Gm. every six hours. This, while clinically effective, gave very irregular blood concentrations, varying from 2-13.5 mg. per 100 cc. This irregularity in absorption and in the amount of drug acetylated is found with other sulfonamides, including sulfadiazine, and seems to some extent to depend on the patient rather than on the drug or the disease. Estimation of the blood level is not required as a routine—Flippin and his colleagues, working with sulfapyridine and sulfathiazole, found that the therapeutic respone in pneumonia was as good with a blood level of two mg. as with fifteen mg. per 100 cc.—but in any patient not responding within two days to treatment, the blood concentration of the drug should be determined, and if it is below three to four mg., dosage should be increased or several doses of the drug given intravenously. In the series of pneumonia cases clinical improvement was usually noticed within twenty-four hours, and a fatality of 6.8 per cent was almost identical with that of an earlier and larger series treated with sulfapyridine. Toxic effects were very few; only five of the seventy-three patients had transient nausea and vomiting; one had late jaundice, two had rashes, and one gonorrheal case had drug fever. There were no renal complications although urines were repeatedly examined for crystals, but, oddly enough, renal complications do not seem to be common in cases of pneumonia treated with other sulfonamides. The rapid response to intravenous therapy in two comatose cases of meningococcal meningitis indicates the value of this form of medication in severely ill patients.—The Lancet.

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MEDICAL CARE FOR THE INDIGENT

Ralph W. Callahan*

Topeka, Kansas

The article on "Medical Care for the Indigent in Shawnee County" published in the December issue of the Journal has brought forth a number of questions, some of a general nature on the plan and others concerning the actual mechanics. Considerable study has been given to various types of medical plans by the Bureau of Medical Economics of the American Medical Association as well as your own state Society. Out of these studies and experiences have come ten sound, well established principles based on the tradition and ethics of the profession. These principles can very well be used and should be used in the establishment of any good plan for the care of the medical indigent.

The following answers to the various questions are conclusions based on the studies referred to herein as well as my own study and experiences with the problem.

Why the need of indigent medical plan?

This question, a little over a decade ago would not have been so easy to answer, but today, an average size book could very well be written in the affirmative and strictly from the professional view point. Custom no longer decrees that "professionally and traditionally the poor are medically the responsibility of the profession."

The general care of the indigent is not fundamentally and definitely not exclusively a problem for the medical profession. Their care is a broad social problem. It is no more the problem of the physician than any other citizen except in the field of medicine.

In this it involves co-operation with the public, private welfare agencies and philanthropic organizations, and here the function of the profession is principally to see that the quality of medical services is maintained and that medical care of the indigent does not become a wedge for the introduction of undesirable methods of control and distribution of medical services. This function cannot be accomplished by the individual members working independently. It can only be accomplished thru correlation and the organized efforts of the county society.

Funds are now available through governmental agencies and various political sub-divisions that will relieve the profession of some of the financial burden the profession has assumed in the past in caring for this type of case. When these funds are pooled with the professional resources of the individual physician through the county society, experience has taught us that it works to the mutual interest of physician and patient.

An indigent medical plan organized by the county unit and well managed will "knock the props" from under those theorists who have clammered vociferously and long for State Medicine.

What constitutes an indigent person?

The term "indigent" designates those who have been declared by a public or private Social Agency after investigation, as being incapable of providing themselves and dependents with the essentials of life. The Kansas Statute also designates them as "those who have insufficient income or resources to provide the necessities of life compatable with decency and health."

Custom has decreed, also the Kansas Statute in effect that medical care is among the essentials to be provided not only for those who are in need of public assistance for food, clothing and shelter, but for those who even if they are able to provide these for themselves do not have sufficient income or resources with which to meet the emergencies caused by sickness. This type of patient has been properly designated as "Medical Indigent." No better definition of "Medical Indigent" could be made than that suggested by the House of Delegates of the American Medical Association at a special session in September of 1938. It is as follows:

> "A person is medically indigent when he is unable, in the place in which he resides, through his own resources, to provide himself and his dependents with proper medical, dental, nursing, hospital, pharmaceutical, and therapeutic appliance care without depriving himself or his dependents of necessary food, clothing, shelter and similar necessities of life, as determined by the local authority charged with the duty of dispensing relief for the medically indigent."

While indigent and medical indigent persons present practically the same economic problem so far as the medical profession is concerned, it must be remembered that generally speaking, there is a distinct difference between the two groups and this article deals with those declared indigent by an official agency.

With the present shortage of physicians for care of the civilian population, wouldn't indigent medical care plan only increase the work of the already overworked profession?

No! Quite to the contrary. We assume these people in need of medical attention are being cared for by the profession at the present time. It would not be a matter of adding new patients, it is simply a matter of the county unit working together and correlating their efforts. When much is to be done

*Executive Secretary, Shawnee County Medical Society.

on limited resources, it is an undisputed fact that anything organized and correlated can accomplish more with less effort than individuals working independently. This applies to medicines as well as anything else. Here we are thinking in terms of efficient distribution of medical services and resources only.

Can these plans be operated in any size county?

Yes. These plans can be successfully operated in any county where there are three or more physicians. The plan must of course be adjusted to the existing conditions within the county.

How are plans controlled?

The control of the plan should always be in the hands of a committee selected by the society and given executive authority in the operation of the plan.

How are funds collected and what are the administrative costs?

Under this plan the individual indigent is usually allowed a stipulated amount in his monthly allowance which he pays into the society at some designated place. In counties of thirty-five thousand or less population, arrangements can usually be made through a bank or individual for the collection and the required bookkeeping at a very reasonable figure. Usually it is not a very good plan to handle this in any physicians' office. In the larger county, full or part time managers should be employed depending on the size of the county. The person employed should be of proven administrative ability, having a good understanding of the problems of the profession with a thorough knowledge of health and public welfare laws. Total administration costs should not exceed eight per cent in any county.

Does the three dollars per month collected in Shawnee County cover an individual or family?

The three dollars per month covers a family unit. This may mean a single individual or it may mean a father, mother and several children. The three dollars covers hospitalization, medical and surgical care and drugs. While this fee meets the operating expenses in Shawnee County, it might be too low in some other county for the same services rendered. In other words, the amount set for a family unit will depend somewhat on the physical resources within the county.

How can services be defined?

Paragraph five of the Shawnee County contract as published in the December, 1942, Journal can very well be used in any county. Much time and study was given to this definition of services to be rendered. It has been cleared through legal channels and has also been approved by the State and county society as well as the State and Federal Public Welfare Agencies.

How are funds distributed to the participating members?

After all current bills have been paid for any given month, including hospitalization and drugs, the balance is pro-rated among the participating members on a unit basis in accordance with professional services rendered.

There are still many questions concerning the actual mechanics of an indigent medical plan that could be answered if time and space would permit but the important points are for the county society to establish the policies and control the plan also to use the ten principles referred to in pages thirteen and fourteen of Organized Payments for Medical Service, A.M.C., 1939.

SERODIAGNOSTIC TESTS FOR SYPHILIS

In a recent letter to Dr. F. C. Beelman, Secretary and Executive Officer of the Kansas State Board of Health, relative to the 1942 Federal Evaluation Study on the Performance of Seriodiagnostic Tests for Syphilis, Dr. Thomas A. Parran, Surgeon General, United States Public Health Service made this statement: "According to the standards which have been used since 1938, the performance of the Kahn Standard, Kline Diagnostic and Kolmer Quantitative Complement Fixation tests in the laboratory of the Kansas State Board of Health are satisfactory."

For a number of years the Committee on Serodiagnostic Tests for Syphilis in cooperation with the United States Venereal Disease Research Laboratory of the United States Public Health Service have been conducting these annual evaluation studies. The committee on evaluation studies consists of the following:

Thomas Parran, M.D., Surgeon General, USPHS, Washington, D. C.

H. H. Hazen, M.D., Washington, D. C.

J. F. Hahoney, M.D., Senior Surgeon, USPHS, Stapleton, New York.

Arthur H. Sanford, M.D., Rochester, Minnesota.

F. E. Senear, M.D., Chicago.

Walter M. Simpson, M.D., Dayton, Ohio.

R. A. Vonderlehr, M.D., Asst. Surgeon General, USPHA, Washington, D. C.

The purpose of these studies is to determine whether the state laboratories are performing their serologic tests for the diagnosis of syphilis in a satisfactory manner. Since the evaluation studies have been started, there has been a marked improvement in the quality of work. Only by the employment of studies of this kind can the work of any laboratory

(Continued on Page 11)

President's Page

THE HOME FRONT

To the Members of The Kansas Medical Society:

We know that the high character, fine training and outstanding ability of the Kansas doctors in service will insure the finest of medical care for our soldiers and sailors on the war front wherever our doctors are serving. To the doctors of medicine remaining at home comes the equally important duty of maintaining adequate care of the civil population on the home front.

A recent survey of the medical situation in Kansas by the State Procurement and Assignment Committee gives a clear picture of the medical care available to the people in our State. The Procurement and Assignment Committee has fully met its obligations to the armed forces of the county as evidenced by the overfilling of our State quota for doctors by fourteen per cent. Equally important, the Procurement and Assignment Committee has remained cognizant of its duty to maintain a proper number and a proper distribution of physicians on the home front for the furnishing of adequate medical care to the public. Certainly, for the size of the project, a very minimum number of mistakes have been made in this State.

However, there are a few communities and, in an occasional instance, a more sparsely settled county, with no doctor of medicine available and I would like to make the plea that wherever this condition exists, that the physicians in adjacent communities or counties get together in a local meeting and formulate some plan for making the services of a physician available. The maintenance of an office three half days a week in such communities or in the county seat of these few counties would greatly alleviate any difficulties. This would probably entail extra work and hardship on the physicians doing this but it is an excellent way of contributing to the total war effort. May I ask that every member of our Society take upon himself the duty of seeing that no adjacent community or county is left without adequate medical care. Call whatever local meetings are necessary to devise the best solution for any of these problems. No greater war service than this can be rendered.

Sincerely,

Henry N. Ickes, M. D.

President, The Kansas Medical Society.

EDITORIAL

WAR PARTICIPATION PLAN

An important communication has been received in the central office from the Office of Emergency Management of the War Manpower Commission of Washington, D. C. and signed by Dr. Frank H. Lahey, Chairman of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians:

"It is of the utmost importance that the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, immediately has the name of any doctor who really is willing to be dislocated for service, either in industry or in over-populated areas, and who has not been declared essential to his present locality. This is necessary if the medical profession is to be able to meet these needs adequately and promptly. We urgently request that any physician over the age of forty-five who wishes to participate in the war effort send in his name to the State Chairman for the Procurement and Assignment Service in his State."

On page 24 of this issue will be found a blank with all necessary data to be filled in. The blank should be mailed at once to Dr. F. L. Loveland, 406 Columbian Building, Topeka, if you have not been declared essential, are over forty-five years of age, and desire to dislocate yourself from your present location and to participate more fully in the war relocation effort.

KANSAS MILITARY HONOR ROLL

The Journal last month published the names of 428 Kansas physicians who are at the present time serving in the United States armed forces. Thirty-one names are being added to this original Military Honor Roll and from time to time others entering the service will be listed as the information is received.

The Editorial Board has also found that in quite a few instances the military status of the men listed was in error, due to the advance in commission from the original information received.

The central office and the Journal will greatly appreciate receiving any further information regarding changes in rank or the names of men entering the service in the future.

ATCHISON COUNTY

Byrne, Ralph*—Atchison, Lt. Comdr.....Navy

BOURBON COUNTY

Irby, A. C.—Fort Scott, Lt. Comdr.....Navy

CHEROKEE COUNTY

Wolohon, Harry G.—Scammon Army

CLAY COUNTY

McIlvain, Guy B.—Clay Center, Captain.....Army
McVey, Roy B.—Clay Center.....Army

EDWARDS COUNTY

Johnson, Charles H.—Kinsley.....Army

HARVEY COUNTY

Buehler, C. T.*—Lieutenant.....Army
Miles, Paul W.—Newton, Lieutenant.....Army
Rhoades, Gordon—Captain.....Army

JOHNSON COUNTY

Muller, Samuel B.—Overland Park.....Army

LEAVENWORTH COUNTY

McKee, Richard S.—Leavenworth, Captain.....Army

LYON COUNTY

Foncannon, Frank—Emporia Army
Bynum, Frank L.*—Emporia.....Army
Morgan, David*—Emporia Army
Butcher, Thos. P.—Emporia, Captain.....Army

MC PHERSON COUNTY

Price, V. C.—McPherson, Lt. Comdr.....Navy

MIAMI COUNTY

Keeton, Elvin E.*—Paola (Reported Killed in Action).....Army
Robb, T. P.*—.....Army
Speer, Louis N.*—Osawatomie, Lieutenant.....Air Corps

MORRIS COUNTY

Melchert, H. B.—Council Grove, Captain.....Army

SHAWNEE COUNTY

Funk, Edward D.*—Topeka, Lieutenant.....Air Corps

WASHINGTON COUNTY

Knauff, Harry C.*—Mahaska, Lieutenant Army

WILSON COUNTY

Dewey, Charles H.—Buffalo, Major.....Army

WYANDOTTE COUNTY

Holter, Harold V.—Kansas City, Lt. Comdr.....Navy
Davis, G. W. Jr.—Kansas City, Lieutenant.....Army
Ellis, Ralph Carlisle*—Kansas City, Captain.....Army
Etzenhauser, Merrill H.*—Kansas City, Lieutenant, J. G. Navy
Lalich, Joseph J.*—Kansas City, Coptain.....Army
Mellott, L. B.—Kansas City, Captain.....Army
McKean, Willis H.—Kansas City, Captain.....Army
Phillips, Frederick N.*—Kansas City.....Army

*Not members of The Kansas Medical Society.

Note: We have been informed that the name of Dr. Guy Finkle of McPherson County should not have been listed as in active service. Dr. Finkle is an officer in the reserve army and practicing in McPherson at the present time.

DR. GEORGE W. CRILE AND DR. HOWARD A. KELLY

During the past week has occurred the deaths of two of the most famous men in their generation, Dr. George W. Crile of Cleveland, the founder of the Cleveland Clinic and a great contributor to the advancement of surgery, and Dr. Howard A. Kelly, the remaining member of the "big four" of Johns Hopkins University Medical School.

Dr. Crile has held the presidency of the American College of Surgeons and for many years has been a

member of its Board of Regents. He has been internationally known in the field of goiter surgery and the author of many books on shock and other surgical subjects.

Dr. Kelly was the first professor of gynecology and obstetrics of Johns Hopkins University and held this chair until 1919. He was also a pioneer in the use of radium for the treatment of cancer of the uterus and contributed many books on a wide range of medical subjects.

This brings to a close two outstanding careers in the science of medicine.

"MORE MEDICAL OFFICERS NEEDED AT ONCE"

"The Surgeon General has sent out a call for volunteers for the Medical Officer's Reserve Corps. There are (April 8) 15,174 officers on active duty, 15,000 of these will be required for service with the army in France in a very short time."

"Within a few months the second draft is to be made and this followed by other drafts, and these will require a considerable number of medical officers. There are few now on the available list."

"If any of you are waiting for the time when you are needed, you can go right now to the nearest board and make your application. Do not give up your practice until you are notified that you will be called. You will be given time to arrange your business."

History repeats itself as the above was printed in the April, 1918, Journal of The Kansas Medical Society. Although figures on the medical status of the war are not quoted the war comparison is an interesting one with the headlines in our medical publications reading as follows: "Need of the Army for Physicians," "Army Recruiting Board Installed," and "Procurement and Assignment Committee Meeting."

A POSSIBLE SOLUTION

Probably no section of the country is immune from some one or two physicians, who, in giving medical testimony, consciously avoid the truth, but this insignificant minority becomes a significant annoyance to the vast majority of honest doctors of medicine who pride themselves on their unassailable reputation for integrity in or out of court.

According to an article in The Journal of American Insurance, the Minnesota State Medical Association has a committee called the Committee on Medical Testimony who after thorough investigation take disciplinary action when needed. This varies from censures to recommendations to the State Board of Medical Examiners that the license of the offending physician be revoked. This committee has been given excellent cooperation by the Minnesota courts. The Justice of the Supreme Court of the State of Minnesota, stated, "You of the Minnesota State Medical Association have the credit of being the first to meet the issue professionally, constructively, and practically. The eyes of the whole American Bar and particularly of all state judicial councils will be, if they are not now, watching your experiment. You are in sole charge of it. We mere lawyers must stand by to render such aid as may be possible."

E. M. Hammes, M.D., of St. Paul, is chairman of this committee. Dr. Hammes states succinctly, "Those who deliberately deviate from the truth on the witness stand are as guilty of unethical practice and as deserving of severe disciplinary measures, as those who violate other rules of ethical practice. I am positive that already there has been a softening of testimony by a few of the men who have been pretty liberal in their testimony in the past. These men know that there is a committee on medical testimony and they also know that excerpts from their testimony—if it shows any traces of dishonesty—in all probability will be referred to the committee by the court, by attorneys, or by physicians themselves. * * * * Medical testimony in Minnesota is of a very high standard but, unfortunately, a rare few need watching—and they realize they are being watched."

It might be well in Michigan that such a committee should function to clean our ranks of the few who forget the responsibilities of their profession.—The Journal of The Michigan State Medical Society.

TUBERCULOSIS CONTROL

TUBERCULOSIS AND THE WAR—HERE AND ABROAD

THE UNITED STATES

The world conflict of 1914-18 for the first time revealed tuberculosis as a major problem. From the early discovery of large numbers of tuberculous troops in the French army to the final assemblage of mortality records of the war years in the civilian population of all countries engaged, it was evident that tuberculosis was exacting a great toll, unrecognized in the wars of previous years. There

is every reason to believe, however, that long wars accompanied by privation have always led to increase in tuberculosis. Crowding, malnutrition, exposure to infection and hardship of every sort have been considered responsible in different degree.

Fortunately, a quarter of a century of research since the last World War has led to a better understanding of methods for control of tuberculosis. Countries fearing the ultimate outbreak of hostilities, through the tense years preceding their final advent, anticipated tuberculosis as a grave menace and prepared accordingly. But in spite of forewarning and preparation, a rise in tuberculosis mortality rates appears already evident. Modern war is total war. Whole populations are engaged, through accelerated industry as well as actual combat.

In the present World War increasing effort is being made in the United States to avoid induction of soldiers with tuberculosis. Measures ensuring x-ray examination of practically all recruits admitted to the armed forces are in effort.

In the civilian population precautions are being taken against nutritional deficiency, since it is almost universally believed to have important bearing on the problem of resistance to tuberculosis. However, malnutrition may not be the gravest predisposing factor in a rise of tuberculosis. The acceleration of industry, leading to crowded quarters in industrial districts, brought about by the mass migration to industrial centers, has created another opportunity for wide-spread infection.

It is evident that a grave menace exists of another world-wide recrudescence of tuberculosis. Its prevention will require vigorous effort against the spread of infection and all measures possible to maintain a high level of resistance to disease.—War and Tuberculosis, Esmond R. Long, Amer. Rev. of Tuber., June, 1942.

BRITAIN

To what extent the tubercle bacillus will repeat its former triumph of a generation ago in Britain cannot yet be properly gauged, but it has taken the initiative and the future course of events will be greatly determined by the effort put forward now by tuberculosis workers.

Deaths from respiratory tuberculosis increased about six per cent the first year of the war and ten per cent the second, while the increase in deaths from other forms of tuberculosis was 2.4 per cent the first year and 17.6 per cent the second.

A considerable amount of infection is evidenced among the general population, particularly children, which means that either the infecting dose is large, or the resistance low. Both causes may have operated in the first half of 1941 when the nightly bombing of towns and cities made contact infection probable and frequent. However, if the increase is found to have continued since more normal conditions have prevailed, it will strengthen the idea that there has been a general lowered resistance to infection in children under five. Many factors can have contributed to the lowering of resistance in children among which are change in diet, non-pasteurized milk, blackout and shelter conditions and lack of sleep and rest.

Comparing the trend of events during the first three years of the last war and available figures for World War II, a definite similarity can be traced, although living conditions now are probably more conductive to the spread of tuberculosis. However, there are some marked differences. Tuberculous meningitis has increased sharply, whereas in the corresponding period of the last war it fell almost to the pre-war level. A further point of difference is the small variation between the male and female curves.

These are ominous signs which mean that infection is lurking in hidden places taking its toll, especially in infant lives, and which emphasize the urgency of means for discovering these nests of infection and the need for their adequate control.—A Further Review of Tuberculosis in Wartime, F. Heaf and L. Rusby, Tubercle, May, 1942.

FRANCE

Food rationing started throughout France on October 1, 1940, when the following foods were restricted: bread, meat, cheese, fats, sugar, milk, chocolate and milled products. Technically other foods could be obtained, but in reality it was difficult to get them. The results of a survey carried on by the Institut des Recherches d'Hygiene on how different families of Paris were feeding themselves showed a total caloric insufficiency of about a thousand calories daily, a calcium deficiency and a calcium-phosphorus imbalance and an insufficient intake of Vitamin A.

Undoubtedly morbidity and mortality from tuberculosis have noticeably increased in Paris. The percentage of rapidly-developed tuberculosis has gone up in an alarming manner. Comparing the figures of the first six months of 1941 with the corresponding ones in 1939, the mortality from tuberculosis increased ten per cent.

Four basic diets were prescribed for sick persons in four specific categories. To lessen the ill effects upon persons with active tuberculosis and known lesions, a diet was given which corresponded to their general category, plus a supplementary amount of forty-five grams of meat and fifteen grams of fat

daily per patient. Despite the precaution indicated, the march of tuberculosis up to Ocober, 1941, had been ominously progressive; thus if the present dietary regime continues and the consequences increase, the problem of tuberculosis in France will be exceedingly grave.—Food Rationing and Mortality in Paris, 1940-41, Ramon F. Minoli, Milbank Memorial Fund Quarterly, July, 1942.

CANADA

The fall in the death rate from tuberculosis in Canada, which has been so evident for the past quarter of a century, has occasioned in some quarters a false sense of security. Nothing could be more unsound or misleading. A disease that kills nearly 6,000 of the population, leaves at least 30,000 incapacitated, and costs the country directly at least $8,000,000, annually, is still a formidable enemy and a major public health problem.

If control of tuberculosis is to be maintained in wartime, tuberculosis services must be continued, problems that arise as a result of the war must be attacked and advantage taken of wartime case-finding projects. Case finding has kept ahead of treatment facilities, which have been inadequate, and until both are developed to a greater degree, control of tuberculosis is still hidden in the future.

Two of the most important phases of case-finding services available are (1) for the general practitioners to provide an early diagnosis, since this is still the greatest source of cases, and (2) examination of contracts, the next greatest source.

Two opportunities have presented themselves as a result of the war: the x-ray examination of all recruits for the armed forces and case-finding projects among industrial workers, particularly in war industries. Tuberculosis is two and a half times as great in industry as in the general population. Therefore, the control of tuberculosis is an important phase of industrial hygiene.

Emphasis is being placed on retaining the open case of tuberculosis in sanatoria. Every patient who leaves against advice represents a weakness in the tuberculosis control system. The factors involved should be carefully analyzed and every way possible must be sought to remedy conditions in institutions to offset this failure in efficient segregation.—The Control of Tuberculosis in Wartime, G. J. Wherrett, Can. Public Health Jour., Sept., 1942.

SERIODIAGNOSTIC TESTS FOR SYPHILIS

(Continued from Page 9)

be evaluated. The results of this study is based upon 359 blood specimens which were sent to us, of which 240 were from syphilitic donors and 129 from presumably non-syphilitic donors. Following are the results:

	Sensitivity	Specificity
STANDARD KAHN		
Kansas	80.4	100
Control (Kahn)	80.7	100
KOLMER QUANTITATIVE		
Kansas	81.8	100
Control (Kolmer)	84.9	100
KLINE DIAGNOSTIC		
Kansas	86.3	100
Control (Kline)	83.1	100
KLINE EXCLUSION		
Kansas	90.7	99.6
Control (Kline)	86.5	100

To qualify as satisfactory, a laboratory should attain a sensitivity rating of not more than ten per cent below that of the control laboratory and a specificity rating of not less than ninety-nine per cent. By sensitivity is meant the ability to pick up true positive reactions from syphilitic donors. Specificity refers to the percentage of negatives and doubtful reactions from presumably non-syphilitic donors or in other words to determine if the laboratory is picking up false positive reactions.

In studying the results obtained by the Division of Public Health Laboratories, it will be noted that a very high rating was obtained in all tests.

NEWS NOTES

LEGISLATION

The House of Representatives and the Senate chose officers for the 1943 Legislature at party caucases held on January 11 and announcement was made at the first session held on January 12. Senator Kirke W. Dale of Arkansas City was elected as President pro-tem of the Senate and Mr. Paul R. Wunsch of Kingman was elected as Speaker of the House. Other officers elected were as follows: Mr. R. C. Woodward of ElDorado as majority-party floor leader; Mr. George W. Fowler of Dodge City as minority-party floor leader; Mr. Paul Sundgren of Coldwater as Speaker pro-tem of the House; and Senator Robert S. Lemon of Pittsburg as minority-party floor leader in the Senate.

Lieutenant Governor Jess Denious of Dodge City, who appoints the Senate Committees, has announced that the following Senators will serve as members of the Senate Committee on Public Health:

Senator W. A. Barron—Phillipsburg, Chairman.
Senator Robert S. Lemon—Pittsburg, Vice-Chairman.
Senator Joe R. Beeler—Jewell.
Senator Willard R. Brown—Emmett.
Senator J. B. Carter—Wilson.
Senator Elmer E. Euwer—Goodland.
Senator M. V. B. Van De Mark—Concordia.

The House Committee on Hygiene and Public Health, which is appointed by Mr. Paul R. Wunsch is as follows:

Representative John A. Holmstrom—Randolph (Riley County), Chairman.

WARTIME BOOM IN BABIES



Photograph Camp prenatal support (skeleton indrawn)



Today, more babies are on the way than in any time during the last 20 years! Naturally, there is a corresponding rise in the need and demand for prenatal supports.

The S. H. Camp and Company has developed over a period of more than 30 years—*a complete series* of maternity supports . . . each type scientifically designed and constructed . . . each type giving accurate support to the abdomen, pelvic girdle and spinal column.

In fact, not a single detail which will add to their clinical value has been neglected.

That these garments successfully measure up to the most stringent clinical requirements is evident—since they carry the approval of many leading gynecologists and obstetricians throughout the world.

The Camp series of prenatal supports comprise models suitable for all types of build. Patients are asked to return each month for adjustment of their prenatal supports. This service is given free of charge by all Camp-trained fitters.

CAMP TRADE MARK Supports

S. H. CAMP & CO., Jackson, Michigan
World's largest manufacturers of scientific supports. Offices in New York, Chicago, Windsor, Ont., London, Eng.

Representative K. A. Bush—Harper (Harper County), Osteopath.

Representative Clair Curry—Tribune (Greeley County).

Representative W. C. Daugherty—Syracuse (Hamilton County).

Representative Kemp McFarland—Chase (Rice County).

Representative John H. Mayhew—Trousdale (Edwards County).

Representative I. E. Nickell—Smith Center (Smith County), Osteopath.

Representative George Shellenberger—Ransom (Ness County).

Representative C. A. Smith—Topeka (Shawnee County).

NEW COMMITTEE CHAIRMAN

Dr. Henry N. Tihen, President, announces the appointment of Dr. O. W. Davidson of Kansas City as the new chairman of the Society Committee on Venereal Disease.

Dr. Davidson succeeds Dr. Arthur D. Gray of Topeka who died on October 30.

JOINT COMMITTEE MEETINGS

A joint meeting of the Society Committee on Maternal Welfare and the Committee on Child Welfare was held in Topeka on January 16 at the Hotel Jayhawk.

The subject of maternity care for wives of men in military service and medical care for their children, as provided in the new federal maternal and child health plan Social Security Act, was discussed.

NEW ATTORNEY

Dr. J. F. Hassig, Secretary of the Kansas State Board of Medical Registration and Examination has announced that Mr. Clarence Beck of Emporia has been selected as the new attorney for the Board to succeed Mr. Theo F. Varner of Independence who is in the military service.

Mr. Beck was Attorney General of the State from 1935 to 1939 and previous to that was county attorney of Lyons County for several terms.

COUNCIL MEETING

A meeting of the Council was held in Topeka at the Hotel Jayhawk on January 17.

A considerable amount of Society business was transacted, including reports of the officers, the war emergency and the pending session of the Kansas Legislature. Other important business discussed was federal maternal aid for wives of service men, the 1943 Procurement and Assignment quota, and possible post graduate plans for the year.

1943 DUES

The following bulletin was mailed to the secretaries of the county medical societies on January 7, 1943:

"We are enclosing the official membership report blank for your society for 1943. The front side of the report may be used for the listing of members and the reverse side is provided for the listing of ineligible and other physicians in your county.

The State Society dues for 1943 will be $15.00 per member, which as you know, is in accordance with the action taken by the House of Delegates at the last annual session. Any local dues desired by your society may, of course, be added to that amount.

Members serving in the military forces will be exempt from the payment of State Society dues on the basis outlined in the following resolution adopted by the Council on February 9, 1941:

"On and after January 1, 1941, members of the Society who are engaged in full-time active duty with the United States Army, Navy or Marine Corps may, upon the request of their county medical society, be exempted from payment of Society dues for the period that they are engaged in such full-time active duty.

"Exemption from payment of dues shall be prorated upon a monthly basis equal to one-twelfth of the total annual dues assessed by the Society for the period of exemption which commences on the first day of the month following entrance into full-time active service and terminates on the first day of the month following return to a civilian status."

In order that our records may be correctly maintained, we would appreciate your listing all members of your society serving in the military forces in the membership column of the enclosed report under a heading of "members engagged in military duty." Physicians within this category will be listed as members of the Society for 1943 and will be entitled to all services of the organization.

The issuance of membership cards in addition to our other work presents a considerable task for the central office, and thus if some delay occurs in the handling of your report we ask your forgiveness.

We realize that the collection of dues occasions many difficulties for the secretaries of county medical societies, and we assure you that the Society is particularly appreciative of your assistance. Please feel free to call upon us for any assistance we may be able to give you."—Robert A. Brooks, Executive Secretary.

BOARD MEETING

The Kansas State Board of Medical Registration and Examination has announced that their next regular meeting will be held on May 19 and 20 at the Kansas City Kansas Chamber of Commerce, 727 Minnesota, Avenue.

GOLDEN BELT MEETING

The January meeting of the Golden-Belt Medical Society was held in Abilene with the Dickinson County Medical Society as hosts.

The program consisted of the talking motion picture on "Peptic Ulcer" by Dr. Frank Lahey of Boston, Massachusetts, and Dr. L. P. Engel of Kansas City, Missouri, discussed "Indication for Surgical Treatment of Hyperinsulinism." A dinner was held at 7:00 p.m. and Dr. Russell Cave of Manhattan gave a councilor report followed by the usual business meeting. Dr. E. Raymond Gelvin of Concordia is President of the organization and Dr. L. S. Nelson of Salina is Secretary.

DOCTORS AT WAR

The new radio broadcast series "Doctors at War" was resumed on Saturday, December 26, at 5:00 p.m. eastern time (4:00 central time, 3:00 mountain time and 2:00 Pacific time) and will continue for twenty-six weeks. The

The Menninger Sanitarium

For the Diagnosis and Treatment of

Nervous and Mental Illness

The Southard School

For the Education and Psychiatric Treatment of Children of Average and Superior Intelligence. Boarding Home Facilities.

Topeka, Kansas

dramatized radio broadcast is sponsored by the American Medical Association and the National Broadcasting Company with the official approval of the Medical Department of the United States Army and the Bureau of Medicine and Surgery of the United States Navy.

The new broadcast is a continuation of the story of the fictitious but typical American physician who has now entered the military services of the United States and the series follows the development of the practice of medicine in typical American communities affected by industrial expansion, troop training programs and other war time influence. Many who enjoyed last year's drama of "Doctors at Work" will be happy to know that the program is again on the air.

MEDICAL PRACTICE VIOLATOR

Justice Homer Hoch of the State Supreme Court, on November 7, 1942, affirmed the opinion of the District Court Judge C. W. Ryan, which had been appealed from the Doniphan District Court, in the case of the Kansas State Board of Medical Registration and Examination and the County Attorney of Doniphan County, Appellees, v. E. B. Martin, Appellant. On January 5, 1942, Judge Ryan found Martin guilty of contempt and sentenced him to a fine of $100.00 and sixty days in the county jail.

Some interesting information is contained in the following citations of the case:

SYLLABUS BY THE COURT

1. Physicians and Surgeons—Practice of Medicine Defined. The practice of medicine, within the meaning of G.S. 1935, 65-1005, is not limited to the prescribing of drugs. It includes the diagnosis of a physical ailment and the prescribing or employment of a treatment, for a fee, even though the treatment does not include the us of drugs.

2. Same—Practice Without a License—Injunction—Contempt—Review. Record examined, and held that there was substantial evidence to support the trial court's finding that the defendant was guilty of indirect contempt. (G.S. 1935, 20-1202 and 20-1204) for violating an injunction (1941 Supp. 65-1010 against the practice of medicine without a license.

Appeal from Doniphan district court; C. W. Ryan, Judge. Opinion filed November 7, 1942. Affirmed."

"The practice of medicine and surgery — within the meaning of the statutes relating to the examination and registration of doctors of medicine and surgery (G.S. 1935, art. 10, ch. 65)—is defined in section 65-1005. We need not quote the section in full. Among the persons regarded as engaging in such practice is included any one "who shall use the words or letters 'Dr.,' 'Doctor,' 'M.D.' or any other title, in connection with his name, which in any way represents him as engaged in the practice of medicine or surgery, or any person attempting to treat the sick or others afflicted with bodily or mental infirmities."

The "practice of medicine," within the statutory definition above, is not limited to the prescribing for a fee of a treatment for its relief is the practice of medicine even though the prescribed treatment does not include the use of drugs. (Slocum v. City of Fredonia, 134 Kan. 853, 857, 8 P. 2d 332.) In State v. Johnson, 84 Kan. 411, 416, 114 Pac. 390, it was said:

"But medicine and surgery, which the appellee is charged with attempting to practice, by common use and adjudged meaning, cover a wide portion of the domain of healing, and may and should be held to cover the case of one who, not claiming to be a physician or surgeon, really practices osteopathy under another guise without possessing the qualifications required of the osteopath."

Our cases are in line with the general rule. The treatment prescribed may be manual manipulation of portions of the body or even the taking of a trip, or sleeping in the open air, etc. (41 Am. Jur. 152, 153; State v. Smith, 233 Mo. 242, 260, 135 S.W. 465.)

However, we may briefly summarize the testimony offered in support of the accusation. Mrs. Gabriel and the defendant both testified that the defendant examined her back and told her that he thought her trouble resulted from "nerve pressure" or a "nerve pinched," and that he gave her four or five manual treatments or "adjustments." Each time she was treated she left a dollar on the table as she went out. Appellant made no claim to being an osteopath or a chiropractor. The treatments given to Mrs. Gabriel constituted the practice of medicine, under the statute and the authorities above cited.

As to the medicine delivered to Cordonier by appellant, it is true that there was testimony that appellant refused to diagnose Cordonier's ailment and sent him to Doctor Meluney but there is no evidence that appellant received any oral prescription direct from Doctor Meluney. What was delivered to Cordonier was characterized as "pills" or "powders" or "herbs" or "parsley roots," and it was admitted that they were medicines. Cordonier testified that he took the tablets three times a day because that is the way the appellant "prescribed it"; that appellant didn't tell him what the "powders" or "herds" were for but told him "they would take care of me." Appellant testified Cordonier paid 25 cents, the first time, for the medicine. Cordonier said he paid $1.25. Appellant testified that he did a retail business of selling packaged medicines, in unbroken packages, under a license from the State Board of Pharmacy, but that the license was issued to his wife.

It is not our function to weigh conflicting evidence or to pass upon the credibility of witnesses (Bullock v. Kendall, 80 Kan. 791, 104 Pac. 568; Gallagher v. Menges & Mange Const. Co., 146 Kan. 506, 72 P. 2d 79).

The record prevents our saying that the trial court has no substantial evidence upon which to find that the appellant had practiced medicine in violation of the injunction.

Mr. Clarence V. Beck of Emporia, attorney for the Kansas State Board of Medical Registration and Examination argued the cause.

NEW DIRECTOR OF VENEREAL DISEASE

Dr. Regnar M. Sorenson, Surgeon of the United States Public Health Service, formerly of Des Moines, Iowa, has been detailed by the United States Public Health Service as Director of the Kansas State Board of Health Division of Venereal Disease Control.

Dr. Sorenson attended the University of Nebraska and the University of Minnesota from which he received his certificate in public health. He succeeded Dr. Robert H. Riedel, now a Captain in the Medical Corps of the United States Army, who is on leave from the Board of Health.

ORTHOPEDIC SURGEONS MEET

The American Academy of Orthopedic Surgeons and the Clinical Orthopedic Society have combined their annual meeting which will be held on January 17-20 at the Palmer House in Chicago.

"War Surgery" and its application to civil practice will be the keynote for the meeting and those interested in bone and joint surgery and its allied fields and who are not members of the societies are welcome to attend the sessions,

THE STATE CREATES A PLASTICS LABORATORY

Looking for more ways to put Kansas resources at the disposal of the war program and with an eye peeled toward the post war period, the creation of the Kansas Industrial Laboratory at Kansas University exhibits portents that may have far-reaching effects upon Kansas economy.

This. of course, is but the first step in a move to provide work opportunity for Kansas boys when they are demobilized. to continue job opportunities for Kansas workers recruited by the war produetion program. continue a domestie market for farm produce, and otherwise act to balance Kansas economy.

It is generally agreed that the reason Kansas suffered more than any other state at the hands of the 1929 depression was the fact that it offered no industrial jobs to its young folks. Consequently, almost 82,000 people left the state during "The Thieving Thirties," a few farmers, a few managers, but mostly younger folks who gave up on their home state and sought jobs in aircraft manufacture, air conditioning and other new, progressive prospects.

Only in the milling industry has there been a proper balance between industry and agriculture. If a large proportion of Kansas wheat could be milled in Kansas, why, asked countless Kansans, couldn't other crops and minerals be processed in the state?

Much already has been done to broaden the scope of these raw materials. It has remained, however, for science, its developments released from laboratories into production lines. to give the state its real opportunity. For with the cessation of civilian economy. the normal pace of progress gave a tremendous leap. Motor cars aged, technically, about 20 years. Plastics entered production on a scale beyond comprehension. New methods and processes took over and outmoded old ones overnight.

Because every ingredient now used in the making of plasties is manufactured commereially in Kansas, and with the market so promising for this new industry, it is apparent that immediate steps must be taken.

The $25,000 grant by the Kansas Industrial Development Commission for establishing and equipping the plastics laboratory begins a study of Kansas plastic sources and a careful scrutiny of the characteristics of the many types of plastics that ean be made from these sources.

As soon as information is available, efforts will be made to influenee Kansas manufacturers to establish fabricating plants and to undertake war contracts. In much the same manner as it has functioned during 1942. the commission then will go about helping to obtain contracts for these shops.

After the war, the field is almost unlimited. Two of the huge ordnance plants that are operating on war contracts should be easily converted to the ehemical processing of raw materials into plastics. The airplane plants, now producing in the billion dollar class. offer a primary market and in oil pipelines, chemical apparatus, electrical appliances and insulators. meat packaging and furniture there is a domestic market potential.

Thus the post-war period becomes a challenge to be met by contributing every benefit of Kansas resources during the war.

according to word received in the office from the Chairman, Dr. J. E. M. Thomson of Lincoln, Nebraska.

The speakers for the meeting will include leading surgeons of this country as well as distinguished guests from England, Canada, South America and a sizeable group of Army and Navy Surgeons who have dealt directly with war casualties from across both oceans.

NEW PUBLICATION

A new publication has been announced by the American Gastroenterological Association for publication on January 1, 1943. The Journal which is owned by the association will be published once a month and will be called "Gastroenterology". Publishers will be Williams and Wilkins Company and subscription price is announced as $6.00 per year.

Dr. W. C. Alvarez will be the Editor and Dr. A. C. Ivy the Assistant Editor. The publication has invited contributions on subjects of interest to the specialist and to the general practitioner which deal with the diseases of digestion and nutrition, including their physiological, biochemical, pathological, parasitological, radiological and surgical aspects. Manuscripts should be sent to Dr. A. C. Ivy, Gastroenterology, 303 East Chicago Avenue, Chicago, Illinois, the new home of the publication.

PREPARATIONS IN TREATMENT OF MALARIA

The following information has recently been released by the United States Food and Drug Administration on the report from the National Research Council in which it states that:

"A preparation of one or more of the crystallizable cinchona alkaloids (quinine, quinadine, cinchonine, cinchonidine) for the treatment of malaria should provide daily for seven consecutive days, for adults, at least 20 grains of the alkaloid or alkaloids.

It is the understanding of this administration that the reference to 'Chinchona Alkaloids' includes the commonly used salts of these alkaloids.

The Council states that in making this recommendation it recognizes that twenty grains of the cinchona alkaloids a day do not provide the optimum dose for adults—which should be thirty grains—but that the minimum of twenty grains is specified as a compromise to provide for an effective dose and to conserve the stocks of these alkaloids during the war period.

The Council has expressed the opinion also that the cinchona alkaloids are not effective in the prophylaxis of malaria.

In its enforcement program the Food and Drug Administration will be guided by this authoritative expression of opinion and will regard as misbranded preparations of cinchona alkaloids offered for the treatment of malaria which, when consumed in accordance with the directions in their labelings, provide less than the dosages specified above."

CIVILIAN DEFENSE

The central office is in receipt of the following information recently released from the office of Civilian Defense at Washington, D. C.:

"The Medical Division of the U. S. Office of Civilian Defense, through its Regional Medical Officers and State Chiefs of Emergency Medical Service, has now made emergency provision for the establishment of a chain of Emergency Base Hospitals in the interior of all the coastal States. They will be activated only in the event of an enemy attack upon our coast which necessitates the evacuation of coastal hospitals. Each base hospital will be related to the casualty receiving hospital which has been evacuated and it is expected that the staff will be recruited largely from the parent institution.

"In order to meet a sudden and unexpected crisis without delay, arrangements have been completed with State authorities for the prompt taking over of appropriate institutions in the interior of the State for this purpose and with local military establishments for the transportation of casualties and other hospitalized persons along appropriate lines of evacuation.

"More than 150 hospitals in the coastal cities are in the process of organizing small affiliated units of physicians and surgeons, which will be prepared to staff the Emergency Base Hospitals if they should be needed. These units are composed of the older members of the staff and those with physical disabilities which render them ineligible for military service, and of women physicians. In order that a balanced professional team may be immediately available the doctors comprising units are being commissioned in the inactive Reserve of the U. S. Public Health Service so that, if called to duty, they may receive the rank, pay and allowances equivalent to that of an officer in the armed forces.

"Dr. George Baehr, Chief Medical Officer of the U. S. Office of Civilian Defense, states that the members of these affiliated hospital units will continue to remain on an inactive status for the duration of the war, unless a serious enemy attack occurs in their Region which necessitates the transfer of casualties to protected sites in the interior. Their commissions may be terminated upon their request six months after the end of the war, or sooner if approved by the Surgeon General. Such approval will be given in the event such officer desires active duty in the Army or Navy."

Under a later date the following revised instructions were released to all Regional Directors and Regional Medical Officers, regarding field casualty and ambulance units of the emergency medical service, from James M. Landis, Director, and Dr. George Baehr, Chief Medical Officer:

"Because of the diminishing supply of civilian physicians and nurses and the growing necessity to conserve manpower, the following economies in the organization and operation of field units of the Emergency Medical Service are to be recommended to all State and local Chiefs of Emergency Medical Service for adoption:

"1. Mobile Medical Teams.—Emergency Medical Field Units are to be composed of mobile medical teams and no longer of squads or groups of teams. Each mobile medical team is to consist, as heretofore, of one physician, one nurse, and two auxiliaries.

"2. Express Parties.—Immediately upon receiving an air raid warden's report of a bombing incident with casualties, the Control Center will dispatch only one Express Party to each major incident. An Express Party will consist of one Rescue Team, one Mobile Medical Team, one ambulance, and perhaps one passenger car or station wagon.

"3. Reserves.—Such an Express Party will usually be sufficient to handle a major incident or a group of neighboring minor incidents with casualties. Additional medical and rescue personnel, ambulances, and passenger cars for sitting cases should be held in reserve and should be dispatched by the Control Center only upon subsequent request of the incident physician (head of the mobile medical team) or of the incident officer at the scene.



LIKE THE TURNIP IN THE OLD FABLE THAT REQUIRED THE WHOLE HOUSEHOLD—INCLUDING THE MOUSE—TO UPROOT IT, FEW DISCOVERIES ARE UNEARTHED BY A SINGLE PERSON.

Thus Sterile Solution Adrenal Cortex Extract (Upjohn) had its roots in the accumulated knowledge of the past; through the work of a number of contemporary investigators the possibility of such a product was demonstrated; and finally, through the combined efforts of the research and production departments of The Upjohn Company, the extract was produced in commercial quantities. Sterile Solution Adrenal Cortex Extract (Upjohn) is available in 10 cc. rubber-capped vials at your prescription pharmacy.

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"4. Reduction in Movement and Use of Medical Personnel.—Mass air raids have occurred chiefly, although not exclusively, at night; both night and day raids are now usually sudden and intense. As protection against a sudden and unexpected attack by the enemy, every hospital having internes or residents is urged to have at least one or more mobile medical teams constantly on call so as to be ready to respond promptly to the order of the Control Center. Most alarms are not followed by an enemy attack; the availability of a few mobile teams at each hospital will make it unnecessary in most cities to disturb the depleted and overworked medical profession by requiring them to mobilize at casualty stations throughout the city on every alert. Moreover, the first line mobile medical teams of hospitals also need not be disturbed until medical service is needed at an incident where casualties have been reported. Practicing physicians of the neighborhood should be mobilized to relieve the primary mobile team when there is a continuing need for field services at the incident or when multiple or large incidents make it desirable to activate a casualty station for the care of the slightly injured. Conservation of medical personnel in this manner will, from now on, become increasingly important.

"5. Reduction in Number of Casualty Stations.—Conservation of emergency medical service personnel can also be accomplished by reducing the number of casualty stations which must be equipped and staffed. British experience over three years indicates that most cities do not require more than one casualty station for each 25,000 persons and that they need not be nearer than a mile apart. Casualty stations for the temporary care of minor casualties are required at or near every hospital. They are also required in parts of a city a mile or more from a hospital and in sections which are geographically isolated. Every community is requested to reexamine its casualty stations in the light of these requirements and to eliminate all unnecessary locations.

"6. Economy in the Use of Casualty Stations.—Casualty stations need not be activated in areas where no casualties have been reported. A mobile medical team should always be available at hospitals to activate its casualty station when necessary. A mobile medical team should be dispatched or assembled at casualty stations near incidents only when casualties have been reported in that vicinity.

"The mobile team for a casualty station located at a hospital is, therefore, best derived from the hospital; a mobile team for emergency service at casualty stations remote from hospitals should be derived either from a hospital, if within three miles, or from the physicians, nurses, and auxiliaries residing in the neighborhood if more than three miles away or otherwise geographically isolated.

"7. Central Control.—The Chief of Emergency Medical Service or his deputy at the Control Center will keep a record of all hospital mobile teams and ambulances in his district and of physicians, nurses, and auxiliaries living in the vicinity of each casualty station, who are on call for emergency service. He will determine when to dispatch a mobile medical team from a hospital to an incident or to activate community medical personnel for service at an incident or casualty station.

"8. Elimination of Advanced First Aid Posts.—All fixed first aid posts can be eliminated. Experience has shown that under the conditions of darkness, confusion, and dirt that exist at air raid incidents, it is rarely necessary or even possible to establish a temporary first aid post. In the darkness and dirt it is impossible to do much more for air raid casualties on the spot than cover their wounds, control hemorrhage, apply a simple splint, and administer morphine before they are removed to the hospital. Most of this work has already been done by rescue workers and the incident physician by the time the casualty is extricated. Only at a large incident with many casualties may it be desirable to establish a first aid post at an appropriate protected site. Even under these circumstances, it should be used as a base of operations for medical personnel rather than a place where severely injured casualties are brought for treatment.

"9. Rescue Units.—Services of Stretcher teams are required at hospitals for unloading of ambulances. Stretcher teams (and so-called first aid parties) are not required in the field, for whatever first aid is possible at incidents is done by the trained rescue workers under the direction of the incident doctor. To conserve manpower, stretcher teams may be disbanded as soon as the rescue teams have been organized and trained, or they may be transferred to the rescue service. The equipment of a rescue team will hereafter include four stretchers. An intensive training program for rescue workers will be announced shortly.

"10. Ambulance Units.—To reduce the movement of vehicles during an air raid, to economize in driver personnel, and to expedite the transport of large numbers of serious casualties from the incidents to hospitals, as many ambulances as possible should be remodeled so as to enable them to carry four stretchers. The use of one- and two-stretcher vehicles greatly delays the movement of large numbers of casualties to hospitals and may result in needless loss of life. To provide adequate transportation of casualties in mass air raids, exposed cities in the target areas require at least one four-stretcher ambulance for every 10,000 persons, depending upon the location of hospitals and the distances to be covered, and half that number of passenger cars or station wagons for sitting cases. Specifications for the conversion of used cars into four-stretcher ambulances will be provided by the Medical Division, United States Office of Civilian Defense.

"11. Ambulance Depots.—To be immediately available at all times, four-stretcher ambulances and passenger cars (sedans or station wagons) should be parked at hospitals, where drivers are always on duty, or else grouped in ambulance depots located at garages in various parts of the town. Only persons residing in or living in the vicinity of the hospitals or ambulance depots should be assigned as drivers of the vehicles.

"12. Interhospital Ambulance Units.—An additional number of large vehicles such as busses should be promptly available day and night for the simultaneous exacuation of hospitals during an air raid. In heavy air raids it has been necessary to move as many patients from evacuated Casualty Receiving Hospitals to peripheral or Emergency Base Hospitals as from incidents to hospitals within the city. In exposed cities in the target zone, it should be possible to evacuate all patients from a hospital in two or at the most three hours without utilizing the ambulance transportation of the field casualty service."

N. Y. A. GIVES HEALTH REPORT

The Federal Security Agency of the United States Public Health Service of Washington, D. C., recently released the following information in regard to the health of the youth of the nation as reported through the United States Public Health Service and the National Youth Administration:

"Nine-tenths of the youths, ages sixteen to twenty-four, in low-income families are in need of medical or dental care, according to a report released today by the U. S. Public Health Service and the National Youth Administration. Although two-thirds of these young people are physically fit for any kind of work, one-third of them are

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limited by health defects in the work they can do.

"These findings are based upon some 150,000 complete physical examinations of out-of-school youth on work programs of the National Youth Administration. This group of young people is believed to be representative of approximately twelve million American youths from low-income families.

"As compared with other groups of the same ages, the general health of N.Y.A. youth is much the same as that of all American youth, but N.Y.A. young people have received less corrective attention for remediable defects, such as decayed teeth, than have other groups.

"The study, made public by Surgeon General Thomas Parran of the U. S. Public Health Service and Administrator Aubrey Williams of the National Youth Administration, provides important data with respect to the lack of adequate medical and dental care in low-income groups and to the problem of rehabilitating the physically handicapped for employment in war production.

"The physical examinations were made by local physicians and dentists and included an evaluation of each youth's employability in terms of his health status.

"According to the recommendations of the examining physicians and dentists, about 185 health defects in each 100 youths require medical or dental attention.

"Untreated dental caries was recorded for eighty-three per cent of the individuals who were examined by a dentist. The average number of untreated defective teeth per 100 youths was 472, or about five defective teeth per person. Over one-third of the youth had defective vision, but most of the visual defects were slight. More than one in ten were fifteen per cent or more below the average weight for their age, sex, and height; over five per cent weighed twenty-five per cent or more above average.

"Negro youth were found to have a lower rate of total carious teeth. Youth in certain geographic regions, notably the Rocky Mountain and West South Central census regions, had significantly higher rates of dental caries. Prevalence rates of defective vision were higher for females than for males, and higher for whites than for Negroes.

"The 150,000 physical examinations included blood serology, urinalysis, stethoscopic examination, dental examination, Snellen chart reading, ear, nose and throat examination, and in some cases, chest x-rays and fecal examinations."

WAR GAS

The office of Civilian Defense recently released the following information on personal protection against war gas:

"The following information on war gases is supplied for general publication because of the possibility that they may at some time be used by the enemy. If people will remember a few simple facts, they will have no unreasonable fear of this agent.

I. War gases stay close to the ground, for they are heavier than air. To get out of a gassed area, simply walk against the wind or go upstairs.

II. Gas is irritating and annoying to the eyes, nose, lungs, or to the skin, but it is usually harmless if you do not become panicky but promptly leave the gas area and cleanse yourself. A soldier must put on a mask where it is necessary to remain in the contaminated area, but a civilian can

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go up on the second or third floor and literally ignore it if the windows are kept closed.

III. If the gas should get on your skin, you can prevent it from doing much harm by sponging it off as quickly as possible with a piece of clothing, such as a handkerchief, and applying some neutralizing substance, followed by a thorough bath, preferably a shower, with common laundry soap and water.

IV. If you are indoors, stay there with doors and windows closed, and go up to the second or third story. Stay out of basements. Turn off the air conditioning, and stop up fireplaces and any other large openings.

V. Some gases are spread as oily droplets which blister and burn the skin and eyes. If you are outside when gas is used do not look up. Tear off a piece of clothing or use a handkerchief to blot any drops of liquid from your skin and throw the contaminated cloth away. Blot; do not rub, as rubbing will spread the liquid. Then go home, if it is nearby, or to the nearest place where you can wash immediately with soap and water and cleanse yourself in the following manner:

1. Remove all outer clothing outside the house, since gas can be transmited to others from contaminated clothing. Put it preferably in a covered garbage pail.

2. Apply one of the following effective household remedies to the part of your skin that has been contaminated; Chlorox or similar household bleach (for mustard); peroxide of hydrogen (for Lewisite); paste or solution of baking soda if you have no peroxide or bleach. If you do not know the gas, use both peroxide and bleach. Keep bleach and peroxide out of the eyes. Do not waste time looking for these remedies; bathe immediately if they are not at hand.

3. After entering the house, wash the bleach or peroxide from hands with laundry soap and water and then wash the face. Remove the underclothing, place it in a covered garbage pail, and enter the bathroom.

4. Irrigate the eyes with large amounts of lukewarm two per cent solution of baking soda (one tablespoonful to a quart of water), or else with plain water. Use an ordinary irrigating douche bag or an eye irrigator. If you do not have these, let plain warm water pour into the eyes from the shower, washing them thoroughly. Do not press or rub the eyes.

5. Lastly, take a shower, using laundry soap and hot water.

6. If the nose and throat feel irritated, wash them out also with baking soda solution.

7. If your chest feels heavy and oppressed, if you have any trouble breathing, or if cigarette smoke becomes distasteful, lie down and stay perfectly still until a doctor sees you.

8. If blisters develop, be careful not to break them and call a doctor.

Remember: Soldiers require gas masks because they must remain in the contaminated area. Civilians can get out of the gassed area or get above the level of the gas, where they do not need gas masks or protective clothing.

Injured persons, who are gassed, require decontamination before they can be admitted to hospitals. All other civilians can best prevent any serious injury by promptly helping themselves in the manner outlined, using a kitchen or bathroom, laundry soap and water, and a few materials found in every household."

COUNTY SOCIETIES

The Central Kansas Medical Society met in Ellsworth on December 17. Speakers were: Dr. Ray West of Wichita who discussed "A Study of Barren Marriages" and Dr. John Kleinheksel of Wichita who discussed "Diabetes".

The Geary County Medical Society re-elected their former officers for the year 1943 at a meeting held in Junction City on December 7: Dr. A. E. O'Donnell will again serve as President, Dr. C. V. Mennick as Vice-President and Dr. L. S. Steadman as Secretary-Treasurer.

The Marion County Medical Society held a Christmas dinner in Marion on December 18 with the wives of members and the members of the Marion County Dental Society as guests. The dinner was in celebration of the 40th anniversary of the Marion County Medical Society. Sound motion pictures were shown following the dinner.

The Miami County Medical Society held election of the following officers at a meeting held in Louisburg on De-

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cember 9: Dr. J. W. Kelly of Louisburg as President, Dr. P. A. Pettit of Paola as Vice-President, and Dr. W. A. Speer of Osawatomie as Secretary-Treasurer.

At a dinner meeting held in Independence on December 11, the Montgomery County Medical Society elected to following new officers: Dr. Porter Clark of Independence as President, Dr. P. S. Townsend of Coffeyville as Vice-President, Dr. G. C. Bates of Independence as Treasurer, Dr. R. B. Chadwick of Coffeyville as Secretary. The medical officers of the air base were guests of the society at dinner. Lieutenant Frank Newman was the speaker and discussed "Personal Experiences in the Far East", showing colored movies of the various places where he had lived.

The Pratt County Medical Society held a dinner meeting at Pratt on December 11 at which the wives of the members were guests. Following the dinner officers were elected for 1943: Dr. Herbert Atkins of Pratt as President, Dr. Athol Cochran of Pratt as Vice-President, and Dr. John R. Campbell of Pratt as Secretary-Treasurer.

The Sedgwick County Medical Society held a meeting in Wichita on January 5 with the following new officers in charge: Dr. Harvey R. Hodson as President, Dr. J. V. Van Cleve as Vice-President, Dr. Robert H. Maxwell as Secretary and Dr. Allen Olson as Treasurer. A symposium on Poliomyelitis was conducted by the following: Dr. J. E. Wolfe discussed the "Epidemiology," Dr. Paul C. Carson the "Kenny Treatment", Dr. E. D. Ebright the "Pathology" Dr. Charles Rombold "Reconstructive Surgery" and Dr. A. E. Bence discussed the subject in general.

The Wyandotte County Medical Society held a December meeting in Kansas City and elected the following new officers: Dr. D. N. Medearis as President, Dr. W. W. Summerville as Vice-President, Dr. H. W. Day as Treasurer, Dr. W. J. Feehan as Secretary, Dr. L. L. Bressette as Censor and Dr. E. S. Miller and Dr. P. J. O'Connel as Delegates until 1945, Dr. C. Omer West as Delegate until 1944 and Dr. G. M. Tice as Delegate until 1943. The Delegates for 1943 and 1944 were elected to fill the unexpired terms of Dr. M. A. Walker and Dr. T. G. Dillon who are serving in the armed forces.

At the December meeting of the Atchison County Medical Society the following new officers were elected: Dr. W. L. Anderson of Atchison as Preseident, Dr. Arthur Whitaker of Atchison as Vice-Preseident, Dr. F. I. Stuart of Atchison as Secretary-Treasurer.

MEMBERS

Dr. Lewis G. Allen of Kansas City was elected as chairman of the Board of Directors of the Radiological Society of North America at the recent meting of that organization held in Chicago.

Dr. W. J. Biermann of Wichita has recently been made a fellow of the American College of Surgeons.

Dr. L. A. Proctor, formerly of Parsons and head of the Labette county health unit, has recently moved to Corsicana, Texas, where he will establish and be the head of a similar health unit.



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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154: Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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DEATH NOTICES

Dr. Henry Walter Gilley, 92 years of age, died on November 18 at his home in Ottawa. He was born in Columbus, Ohio on June 20, 1850 and was graduated from the Detroit Homeopathic Medical College in 1872. Dr. Gilley had practiced medicine in Ottawa for 68 years until his retirement recently. He was an honorary member of the Franklin County Medical Society.

Dr. Smith Forrest McDonald, 66 years of age, of Severy, died on November 3 after a long illness. He was born in Hardin, Missouri and graduated from the Kansas Medical College of Topeka in 1903. He was a member of the Elk County Medical Society.

Dr. Leon Matassarin, 64 years of age of Leavenworth died on December 6 of a heart attack. He was born on May 17, 1878 at Dorohoi, Rumania and graduated from the University of Bucharest School of Medicine, Bucharest, Rumania in 1901. Dr. Matassarin has two sons and a daughter in military service. He was a member of the Leavenworth County Medical Society of which he was at one time President and later Secretary.

Dr. Merle Parrish, 40 years of age, died on November 8, at his home in Kansas City as a result of a heart attack. Dr. Parrish was graduated from the University of Kansas School of Medicine in 1928 and was a member of the Wyandotte County Medical Society.

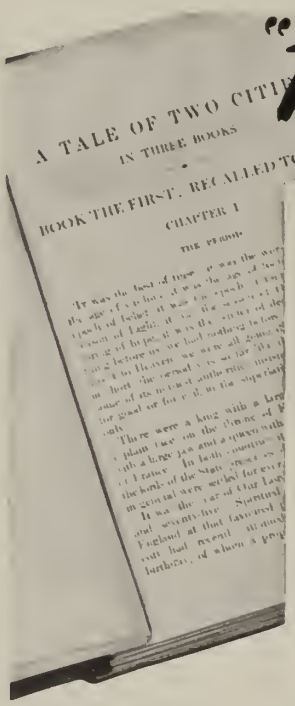
Dr. George Franklin Porter, 57 years of age, died on December 7 at his home in Centerville. Dr. Porter was graduated from the University Medical College of Kansas City in 1910. He was a member of the Linn County Medical Society.

MINUTES

A meeting of the Kansas Society of Obstetrics and Gynecology was held in Topeka at the Hotel Jayhawk on November 19, 1942. Those present were: Dr. Porter Brown of Salina as Chairman, Dr. L. A. Calkins of Kansas City, Dr. Ray A. West of Wichita, Dr. H. R. Ross of Topeka, Dr. Ernest H. Decker of Topeka, Dr. Clyde O. Merideth Jr. of Emporia, Dr. F. C. Beelman of Topeka, Dr. R. E. Pfuetze of Topeka, Dr. Leon Matassarin of Leavenworth, and Dr. Mayer Shoyer of Holton. Jane Skinner was present as Assistant Executive Secretary.

"The meeting was opened by Dr. Brown, Chairman of the Kansas Society of Obstetrics and Gynecology. The speakers who appeared at the meeting were as follows: Dr. Beelman and Dr. Ross of the Kansas State Board of Health. Dr. West as Chairman of the Society Committee on Maternal Welfare, Dr. Merideth as Vice-President of the Kansas Socity of Obstetrics and Gynecology, Dr. Calkins, and Miss Hutchinson from the University of Kansas Hospitals. Miss Hutchinson is chief nurse in charge of Mother's Classes at the hospital.

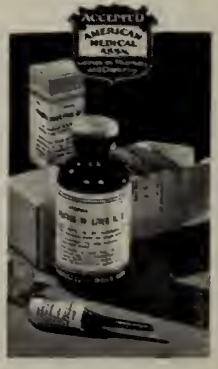
"Dr. Matassarin moved, and the motion was seconded and carried, that the plan for Mother's Classes be accepted



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GYNECOLOGY — Two Weeks Intensive Course starting April 5; Clinical and Diagnostic Courses.
OBSTETRICS—Formal and Informal Courses.
OTOLARYNGOLOGY — Two Weeks Intensive Course starting April 19. Clinical and Special Courses.
OPHTHALMOLOGY—Two Weeks Intensive Course starting April 5.
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by The Kansas Medical Society. The plan consists of the Kansas Obstetrical and Gynecological Society's appointing a carefully selected educational committee to cooperate with Dr. Mayes to bring the mothers' training class program to the attention of the component medical societies and to promote the organization of such classes in various communities with the aid of local women's lay organizations and actually to control and guide the program itself.

"Dr. Calkins stressed the necessity for a nurse trained in conducting Mother's classes.

"Dr. Beelman suggested bringing in Public Health Nurses for a short intensive training.

"It was decided that Dr. Mayes and a member of the county medical society present the above plan to the county medical society. Also that Dr. Brown appoint a member from each county medical society to assist Dr. Mayes in setting up the program.

"Meeting was adjourned."

ANNOUNCEMENTS

The American Board of Obstetrics and Gynecology have announced that the next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Saturday, February 13, 1943, at 2:00 p.m. Candidates in military service taking Part I examination, may do so at their place of duty, with the examination (written) being given by the Commanding Officer (medical). For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

BOOK NOOK

BOOKS REVIEWED

INTERNATIONAL JOURNAL OF SEX-ECONOMY AND ORGONE-RESEARCH — Volume 1, Number 1, March, 1942—This is the beginning of another publication which describes itself as the "official organ of the International Institute for Sex-Economy and Orgone-Research," the director of which is Wilhelm Reich. Dr. Reich is a doctor of medicine who for many years was closely identified with the psychoanalytic movement. His views differed so radically that he organized a new field of psychological thought, and his treatment is termed character analysis. For a while he was closely identified with a publication in Denmark.

This Journal contains papers by Dr. Reich and the editor of the journal, Theodore P. Wolfe, also a New York physician who has identified himself with Reich. The other papers, of which there are four, are apparently written by Europeans and presumably as a means of protecting them they are given pseudonyms.

All the papers deal with an approach to psycho-somatic medicine on the basis that sexual energy and activity is the chief aim of biological life, and as such all behavior is related to this. The papers all deal with the importance of sex, the sharp disagreement with the psychoanalytic school, and a radical approach to the understanding of human behavior.

W. C. M.



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BOOKS RECEIVED

CLINICAL ANESTHESIA, A Manual of Clinical Anesthesiology—John S. Lundy, B.A., M.D., Head of Section on Anesthesia of the Mayo Clinic; Professor of Anesthesia of the Mayo Foundation of Medical Education and Research, Graduate School of the University of Minnesota; Diplomate and Member of the American Board of Anesthesiology, Inc.; Member of the Subcommittee on Anesthesia of the National Research Council. Published by W. B. Saunders Company of Philadelphia, Pennsylvania, and London, England. The book contains 771 pages and 266 illustrations, and is priced at $9.00.

MEDICAL PARASITOLOGY — James T. Culbertson, Assistant Professor of Bacteriology of the College of Physicians and Surgeons of Columbia University. Published by the Columbia University Press, the book contains 285 pages and is priced at $4.25.

THE 1942 YEAR BOOK OF GENERAL MEDICINE—Edited by George F. Dick, M.D., J. Burns Amberson, Jr., M.D., George R. Minot, M.D., F.R.C.P., William B. Castle, M.D., S.M., William D. Stroud, M.D., and George B. Eusterman, M.D. Published by the Year Book Publishers, Inc., of Chicago, Illinois, the volume is priced at $3.00.

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FOR SALE—Entire ultra-modern medical equipment of the late Dr. Harrison B. Talbot for sale—Address Journal of The Kansas Medical Society, C-03. Mrs. H. B. Talbot, 600 West Eleventh Street, Apt. No. 6, Topeka, Kansas.

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AUXILIARY

PRESIDENT'S MESSAGE

Just before Christmas I received this message from Mrs. Frank N. Haggard, President of the Women's Auxiliary to the American Medical Association, which I feel sure she would want passed on to you: "Once more, this time in the midst of war, we are turning our thoughts to Christmas. It will be a difficult day for many loved ones and friends with husbands and sons in the armed forces away from home. Each one of us has a personal responsibility to all the men in service, and we must feel that the Immortal Light burns brighter than ever. Some day—we hope soon—we shall have them home.

War has a way of bringing us face to face with fundamentals, brought to a pause by its elemental demands. We learn to recognize the things that have lasting values; then, we give them their due at last.

There is none among us who is able to go far alone. We must grow from knowledge and research of others. This is true in our Auxiliary work together. Somehow this year Christmas seems to mean to me a keener-than-ever time for appreciation, and I want you to know how much I appreciate you, for your kind understanding of my effort, and for your help. We may not be able to accomplish all that we had hoped, but ours is the obligation to serve in the interest of the medical profession.

Won't you try to have your own Auxiliary contact the doctor's wife whose husband is in the service? A note from her own Auxiliary members will mean much even if she is at home.

My wish for you is that the joys you now have may never diminish, but that others may be added to them. When peace shall come once more to bless us, may your own loved ones be spared for a safe return in happiness of the truest, deepest kind." Sincerely

Mrs. C. Omer West.

AUXILIARY NEWS

The Central Kansas Medical Society Auxiliary met at the home of Dr. and Mrs. Alfred O'Donnell in Ellsworth on December 17. Mrs. Hugh Hope of Hunter a member of the Mitchell County Auxiliary spoke on "Pending Legislation."

The Pratt County Medical Society Auxiliary was entertained with a Christmas dinner at the Park Hill Country Club in Pratt on December 11 by the members of the Pratt County Medical Society.

The Auxiliary to the Sedgwick County Medical Society held a luncheon in Wichita on January 11. Mrs. A. L. Crittenden, program chairman for the meeting, presented Mr. Oliver Ebel, Executive Secretary of the Sedgwick County Medical Society who spoke to the organization on "Medical Headlines and Oddities."

BOOK NOTES

Occasionally we discover an account of how contagious diseases were handled many years ago and are decidedly startled at some of the methods used. We usually do not think of Boston in 1764 as being particularly advanced, and yet the following account of how an epidemic of smallpox was cared for has many aspects which reflect a modern tone. We quote from the excellent biography by Esther Forbes, Paul Rever and the World He Lived In.

"Ten days before Paul Revere had appeared before the selectmen (as the law required and their records show), one of his children had smallpox.

"The selectmen argued with Revere. They wished the child to be removed to one of the dreary pesthouses (often little more than an abandoned dwelling), away from the center of the town. Revere refused. He loved his children—'his lambs,' as he called them. A visit to a hospital in those days was too often fatal. They could not 'prevail upon him.' So it was ordered that a flag be hung in front of his house. Moreover, a guard would be stationed. For this office any man who had had the malady would suffice. They chose Nicholas Murphy. Unlike some of the really wild Irishmen arriving in Boston at the time, Mr. Murphy could read, for they gave him his instructions in writing.

"Revere went back to the house by the wharf. Now the family was locked in upon itself. For the next month his ledgers show no orders. Whether the disease, probably the most contagious of all diseases, stopped with one child or went through the entire family, is not known. But none of them died.

"By the third of March it was everywhere, and all who might were fleeing to the country. Night and day the carts rumbled out of town as 1,537 people abandoned their trades and houses, struggling to get out of the infested town. John Boyle says there will be a total stop of trade 'until the distemper has gone through the town.' The selectmen now decided to grant 'liberty to the inhabitants to inoculate their families!'

"Vaccination, which finally defeated this ancient terror of mankind, had not yet been discovered. The inoculation for which Dr. Boylston and Mr. Mather had fought and nearly died during the great epidemic of '21 and which the selectmen were now ready to risk, was dangerous, not only to the individual, but to the community. 'Venom' was taken from 'the best sort of smallpox,' as much as would lie on the point of a needle, and put directly into an open wound. In this way a light case usually developed, which was, however, real smallpox and exactly as contagious. The patient was soon up and about with as complete immunity as though he had had it 'in the natural way.' The selectmen's decision to permit wholesale inoculation was a dangerous one, but Boston was ready for experimentation in politics, trade or hygiene.

"At the end of June, the epidemic was under control. The selectmen were justified in their decision and gave their figures: 4,977 people had taken smallpox by inoculation, of whom 46 had died; 699 had had it 'in the natural way,' and 124 had died. The Reverend Cotton Mather and Dr. Zabdiel Boylston had not lived in vain."

Among other books worthy of attention are two titles concerning medical history which provide fascinating reading: Modern Medicine by N. W. Wilson and Dr. S. A. Weisman and G. W. Gray's The Advancing Front of Medicine. The first of these titles is especially recommended to those contemplating a medical career, in that particular emphasis is placed on unsolved problems and opportunities.

While Magic in a Bottle by Milton Silverman is not a new book, it is certainly one to back-track and read if one has missed it. Concerned with the discovery, preparation and use of modern drugs such as quinine, digitalis, sulfanilamide, etc., the book reads like an adventure novel. —From the Woman's Auxiliary Section of the Journal of Iowa State Medical Society.

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FUNDAMENTALS OF PSYCHIATRY V

THE PERSONALITY-ENVIRONMENTAL STRUGGLE

William C. Menninger, M.D.

Topeka, Kansas

Until the advent of psychoanalysis, the approach to psychiatry was chiefly on a descriptive level. This means that the physician's chief interest in mental disorders was to outline the symptoms and make word pictures of the various clinical syndromes which he saw. As a result of such an approach, the various disease entities were described and redescribed, with a great deal of detail as to the minute variations of each symptom. With the advent of psychoanalysis, the emphasis changed to one of attempting to understand the meaning and motivation of these symptoms. In contrast to being descriptive, the approach became dynamic, with attempts to answer such questions as Why does he develop this particular symptom? What does it mean? What part does it play in the total picture? What is the motive of his illness? About what kind of a conflict does it center?

To use an analogy, the descriptive method was similar to taking a photograph of an automobile in a show window, or as was more commonly the case, of the wreck by the roadside. The dynamic approach refers to the machine in motion, how the parts are interrelated, and what happened to cause the wreck.

THE PERSONALITY VERSUS THE ENVIRONMENT

To carry the analogy further, it is presumed that we know all about our car. We know the kind of people who made it, we know the kind of "stuff" of which it is made, we know how it was put together, we know how it is supposed to function, and we know that if it has a conservative, steady driver, over good roads, it can cover many miles smoothly and efficiently. Similarly, we know that to understand the personality we must know "the kind of stuff from which it is made," the kind of people who made it (the parents), how its various parts are interrelated —the nervous system, the gastrointestinal system, the blood system, the muscular system, and all the other parts. But any car no matter how well it may be made (and some aren't made very well) may sometimes have bad gasoline or poor oil; some other car may bump into it; its driver may drive it into a culvert; or the road may be narrow or rough or sandy. In other words, even though we may know the car, we can understand its functional stresses and strains only when we are acquainted with the terrain in which it is to be used, namely, the environment. Thus, the stress and efficiency that any car can exhibit is always dependent on the two factors, its construction and the road on which it is tested. Likewise, in the human situation, the functional efficiency of each individual depends on the two factors of (1) his own personality and (2) the environment in which he functions.

Primitive Adjustments: In the lower forms of animal life like the protozoa, the adjustment of the particular organism to its environment may be assumed to be relatively simple. It must engulf food, rest, and divide. We may presume that man as he starts as a single cell likewise has a very simple problem of adjustment. So long as the child is carried in his mother's uterus he has no concerns, no problems, and all his needs are satisfied, but from the minute he appears in the world he has the problem of adjusting himself to his environment. In growing up he meets the increasing restrictions which are placed upon each of us by the demands of a complicated civilization that require us to conform to standards. The personality must adjust to this increasing complexity of the environment and this adjustment is a continuous struggle.

This personality-environmental struggle can be depicted somewhat diagrammatically as a collision beween the personality and an environment. The personality is continuously changing to adjust to an environment which, too, is continually changing. Within an hour's time one may be attempting to adjust to studying from a "dry" text, to hearing some disturbing war news, to caring for a very sick patient, and to enjoying a party with a friend. Each situation is very different and the person conducts himself differently and reacts quite differently in each.

Thus, continually, the person and the environment are colliding, and the outcome of this collision may be success (adjustment) or failure (maladjustment). The failures and their causes are the special interest and field of the psychiatrist.

The failures can result in two types of reaction—flight or attack. In the flight reaction the personality always suffers, in varying degrees depending on the strength of the personality, and the demands made upon it by the environment. Thus, the personality may develop or display undesirable traits like pouting or irritability, anger or depression. It may suffer in some physical disease if the environment happens to include a bullet or a tubercular bacillus. Or the personality may break psychologically with the development of a mental sickness. In every instance, however, the failure represents a kind of flight, a running away from an environment which it can't accept or manage.

When the failure takes the form of an attack the situation suffers: instead of running away the person attacks the environment either to change it or to destroy it. Thus the individual may fight physically. Such a "solution" is futile, costly, and can be regarded only as an expression of the failure to adjust himself to his environment in a more rational way. The attack may take the form of crime; it may take the form of divorce, the person may make enemies; he may wreck his business; but in every attack the individual tries to shatter his environment.

In every instance of maladjustment (failure) whether it be flight or attack there is always the possibility of readjustment. Readjustment usually entails a recuperation of the personality and a reconstruction of the environment. Because most of our failures are minor ones, readjustment is often relatively simple. Sometimes it is a matter of getting a little more sleep; sometimes it is a matter of using a little more intelligence and a little less emotion; sometimes it is only a matter of a little more thoughtful approach to the problem. It is always a matter of a compromise: the personality changes a little and the environment is changed a little. Usually our own reconsideration of the problem is adequate to help us solve it.

Unfortunately, sometimes our failures are so flagrant that we need outside help to recover our equilibrium. When the maladjustment reaches the stage of the "nervous breakdown" or physical disease, or crime, or divorce, we have to call in outside assistance. Occasionally the minister or the social worker, the parent or the teacher, may help sufficiently by changing environment so that we may function a little easier. Sometimes they can turn the trick, but unfortunately, no one can change the world very much. But if help is to be had, most of it must come through a change in the personality. In helping the individual our initial efforts must be directed toward understanding why the particular personality reacts in a particular way to a particular environment. What factors are operative in our make-up which determine the outcome of this struggle?

FACTORS IN THE INDIVIDUAL WHICH DETERMINE THE OUTCOME OF THE PERSONALITY-ENVIRONMENTAL STRUGGLE

When one seeks for the factors which determine the outcome of the personality-environmental struggle, he is really seeking the causes of mental illness, and these are legion. In fact, there is perhaps never one single cause for any mental illness. One must always speak of causes and it is not entirely accurate to say that even a physical disease has a single cause. For instance, ten men may be exposed to pneumonia. Eight of them actually harbor the pneumococcus in their throats, but only one man gets an inflammatory reaction in the lungs. There are other causes than just the pneumococcus, factors that are inherent and specific for each individual.

For the sake of simplicity these factors that determine the adjustment capacity of the personality for his environment are grouped under three headings: the hereditary or constitutional factors, the developmental environment factors, and the precipitating factors.

The Hereditary (Constitutional) Factor: By constitution we refer to all the inherited characteristics and potentialities of an individual. It is known that certain constitutional traits (like the color of hair and eyes) are inherited and that among these may be included certain potentialities or weaknesses of the nervous system which under certain circumstances may eventuate in mental disorders. Certain neurologic afflictions certainly seem to be inherited directly, for instance, feeblemindedness. There is considerable evidence that a tendency toward epilepsy may be inherited, and even more definite evidence that certain types of organic nervous system disease like Huntington's Chorea and amaurotic family idiocy are inherited. It is likely that a certain physical build may be inherited, such as has been described by Kretschmer, in which he associates the long, tall individual whom he calls asthenic, with the particular type of personality which we call "schizoid." The short, fat body structure, the pyknic type, is associated with a type of personality called "cycloid."

It is quite possible that an individual may inherit an unstable nervous system or a tendency to have this part of his personality as the weakest link, but as yet there is no proof of such inheritance. Although an extensive amount of work has been done in studying the heredity of different types of mental disease,

the results neither positively affirm or deny that such transmission occurs. No form of mental disease follows the Mendelian law of inheritance, nor is it passed on directly from parent to child. The tendency may be (though this is not proven) but the disease is not. It is generally agreed that this factor of inheritance has been stressed far too much as the causation of mental illness. Furthermore, in evaluating the heredity, it is impossible to exclude the environment. Each individual inherits an environment, namely, his social strata, his parents, their economic situation, the home, which modifies potentialities and contributes weaknesses that could not be distinguished or differentiated from inherited constitutional potentialities.

In summary, one must recognize the factor of heredity as being present, but its evaluation is very difficult. The diagnostic and prognostic significance of this element is minimal, and treatment has no relation to it.

Developmental Environment Factor. The environmental influences and experiences during the development stages of infancy and childhood are unquestionably of the greatest importance in determining the outcome of every personality-environmental struggle. It is at this period that every individual is predisposed to a good or poor capacity for adjustment as a result of the emotional relationships, the training, and education. The attitude of the parents toward the child, their management of him, and on the other hand, his reaction to them and to the other children of the family serve as the patterns of behavior throughout an individual's life. For instance, the mother is usually the only woman the average child knows through the first five or six years of his life, the period when he is most open to impressions and when he is forming his reactions. It is to be expected that all of his impressions and his attitudes toward women throughout his entire life will be patterned in some degre after this first relationship. Similarly, it is true with the father that all subsequent relations with men are in some degree molded by the relationship with him and older brothers.

To adequately understand any behavior reaction one must necessarily know the details of this early childhood period. It is the most impressionable age in an individual's life, the age when all emotional patterns are formed. At this time he learns to be trustworthy or deceptive, to love and to hate, to be dependent or independent, to be lazy or industrious, to be uncomfortable or at ease with people; it is the golden age for the application of mental hygiene.

We may summarize the influence of the environment during the development of the child as of the greatest importance in understanding reactions in later life. This factor is subject to relatively accurate evaluation; it is of immense value in making both a diagnosis and a prognosis, and it is of paramount importance in formulating and guiding treatment.

The Precipitating Factor: In the majority of mental illnesses one can determine a particular event which marked the onset of the severe mental reaction. In fact, in everyday life situations, one can often see that a minor event seems to "upset" the whole day. In mental disorders such events are regarded often as the cause of the reaction, but although they may appear to be the cause, the psychiatrist regards them as merely precipitating agents.

Mental illness never develops suddenly even though sometimes the acute symptoms do appear in the course of a day or two. In every case where this does occur careful study reveals evidences of adjustment failure in the personality a long time prior to the acute break. In other words, the play has been rehearsed and the stage has been set and the precipitating event merely lifts the curtain. One may think of such a personality as having been forced out on a narrow ledge where he is just able to maintain his balance. If he doesn't get afraid and if he is left undisturbed, he may be able to maintain his balance, but a very trivial event may upset the equilibrium, and then the mental symptoms appear. The precipitating agent disturbs this delicate balance of adjustment. The importance of this precipitating factor may vary with different individuals. The ledge may be very narrow or relatively wide. In the first instance the precipitating event need be very trivial; it may even be insignificant and not be recognized, while in the latter instance, it may appear to be very important and necessarily of major magnitude and importance.

This precipitating factor is apparent even in the organic psychoses. The mental picture in any given case of brain syphilis is the combined expression of the personality prior to the invasion by the spirochete, plus the brain injury (with the spirochete as the precipitating agent). The microscopical changes in the brain in this disease are so similar that even the expert pathologist will not hazard a guess as to the type of symptomatology the patient presented. But one may assume that the jolly, happy, ambitious person whose brain becomes the object of an invasion of spirochetes develops mental symptoms that have a direct relationship to his personality traits before he became ill. Thus the spirochetes precipitate a particular mental picture characteristic of the particular personality.

In the functional mental illnesses the essential causes for the illness are internal stresses which are brought to light in the form of symptoms, as the

result of a particular event or experience. One can classify conveniently these events and experiences under the headings of (1) emotional deprivations, (2) threatened insecurity in adjusting to new situations, and (3) physical or physiological burdens.

The emotional deprivations which at times serve as precipitating factors can be varied. Occasionally economic losses or reverses initiate an illness; a more common cause may be the death of a significant person or persons in the individual's life (the mother, husband, child).

Various forms of threatened insecurity occur in every individual's life in attempting to adjust to new situations. Thus, the child in advancing in school meets new demands which require readjustment and threaten his security. For instance, when the high school student goes on to college he leaves a situation in which he has had many friends and he may have been an important figure in the senior class. He enters a situation where he is a "green" freshman, to be hazed and ridiculed, and otherwise unnoticed. The result is that the great majority of failures in college occur in the freshman year. For children, adjustments to a new family situation are often provocative of failures in adjustment, particularly in such family changes as divorce and re-marriage. For the adult to attempt to undertake marriage may provoke a mental disorder, as may the responsibility of imminent parenthood. Every new job situation requires readjustment; the former employer knew what you could do; the fellow employees knew you; you knew your work. But all is changed in a new position and the threat to security spells failure for some. Childbirth is frequently regarded as the cause of mental illness although not more than one in a hundred women develops a severe mental reaction following this experience. Thus, it is not the process alone that causes the psychosis. Similarly, one must conclude that the psychological readjustment at the time of the menopause is often more than some women can accept gracefully. It is quite possible that during both the puerperal period and the menopause there are physiochemical factors which are of importance, and yet every woman goes through the same procedures, and only a small number develop severe mental symptoms. It is often apparent to the psychiatrist that the mental illnesses which accompany the menopause are associated with and may be the result of some recognition on the part of the woman that her fertile, productive and active stage in life is approaching an end. The adjustment demanded is more than some women can make.

Physical and physiological burdens may act as precipitating agents of mental illness. In this group might be included some instances of childbirth, and of menopause. Certainly, systemic or infectious disease may initiate severe mental reactions. There is no satisfactory explanation as to why one man with a fever of 104 degrees is delirious and other man with the same sort of illness with the same temperature is not. One must assume that the toxin or infection produces such a reaction only in particular types of predisposed personalities. Similarly, injuries, most often of the head but occasionally of any part of the body, may initiate a train of mental symptoms. Focal infections at times may upset this balance of adjustment, and physical exhaustion as it occurs after starvation or extreme exposure or debilitating disease may precipitate a mental disorder.

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A physician in the "late sixties" came to see what he could do during the present emergency. He said, "I am too old to enlist in the Service, but I still am able to carry on and do my share of practice. I am not too busy these days (he is located in a country town not too far from a large industrial center) and I have several hours each day that I might devote to industrial work, such as physical examinations, minor surgical dressings, etc. I want to do something and am wondering just where I will best fit in." Here we have a man who wants to do his bit and is willing to devote several hours each day in "war work." He is in better than average health for his years, has had a long career in medicine and is good for many years to come. Such an offer will not go unnoticed. This man soon will achieve his desire and will be an active part of our great machine—the greatest in the history of the World War.—Journal of Indiana State Medical Society.

A review by W. J. McNally, M.D., and E. A. Stuart, M.D., Montreal, Canada, in the current issue of "War Medicine," of experimental work on the labyrinth or inner ear in relation to seasickness and other forms of motion sickness fails to bring to light any widely accepted explanation for the cause of the condition or immunity to it. "The labyrinth has been shown by experiment to play an important, probably the most important, part in the causation of motion sickness,". the two physicians explain.

BLADDER ULCER

Harry W. Davis, M.D.

Plains, Kansas

While open to question, I do not believe the results obtained in this case were accidental, and should it prove to be of any value full credit should be given to an urologist who one time pointed out to me that bladder pathology may be intimately associated with the colon.

CASE REPORT

Mrs. M—HW sixty-eight years of age. For the last sixteen months she had been troubled with frequent and sometimes painful urination and always had pain and aching in the bladder region. She also said she had been told she had a bladder ulcer which I did not doubt. A specimen revealed an opaque, ropey yellowish urine containing albumin, pus and blood.

She had, during her illness, been treated by several physicians including a competent urologist. In outlining what had been done for her it seemed all available treatment has been tried and found wanting. The different sulfa drugs had been used but nauseated her so badly she had refused to continue them.

The only other remedy I could suggest was neoprontosil hypodermatically which was used and gave her a great deal of relief and comfort. She was extremely grateful that at one time she had two hours of uninterrupted sleep.

Three months ago she developed symptoms of colitis at which time I decided to treat the colon in the faint hope that it might influence the bladder prescribing succinyl-sulfathiazole which she took without untoward symptoms.

In ten days she had improved so much the neoprontosil was discontinued and she has felt better under this medication than at any time during her illness and at this time is the only treatment used. While this proves nothing at all it is offered in hope that it might deserve further trial in similar cases.

A "Workers' Health Series"—Put out by the U. S. Public Health Service is cleverly written and illustrated and should help greatly in educating the public to better health. The titles are: No. 1, But Flu Is Tougher; No. 2, Leonard's Appendix—And How It Burst; No. 3, KO and CO Gas; No. 4, Clara Gives Benzol the Run Around; No. 5, Trouble in the Midriff. The booklets are for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C.

FECALITHS AND GALLSTONES AS CAUSE OF INTESTINAL OBSTRUCTION

Alfred E. Gardner, M.D.

Wichita, Kansas

According to Martin, the first man to record intestinal obstruction due to gallstones was Bartholin, in 1654.

Courvoisier, in 1890, reported 131 cases and stated that spontaneous cure resulted in seventy after passage of the stone per ano. About four per cent of cases of intestinal obstruction, he said, are due to gallstones.

Von Wagner found 334 cases up to 1914.

Powers, of the Peter Bent Brigham Hospital in Boston, reports four cases in 179 patients operated on for intestinal obstruction.

Sieworth, who contributes the foregoing data, quotes Robson to the effect that, in 80,000 hospital patients in four large British hospitals, the condition occurred four times. He states that Martin, while Professor of Surgery at the University of Maryland, sent a questionnaire to a group of surgeons and received replies from twenty-eight, whose experience he estimated at half a million operations. Sixteen cases of gallstone ileus were reported to him.

The case Sieworth reports from Lake View Hospital in Chicago, was that of a woman of sixty. A cholesterin gallstone the size of a hen's egg was found in the lumen of the jejunum, not movable. Her condition became poor; she was in shock and had severe toxemia from vomiting, which became fecal just before operation. A heart stimulant was given, also salt solution and glucose per rectum and intravenously, but the patient died thirteen hours after operation.

That perforation may occur without attending symptoms is shown by Reimann and Bloom, whose patient succumbed to empyema following lobar pneumonia. Although the patient was jaundiced, there was no previous history of gallbladder disease. Postmortem examination revealed a biliary fistula between the gallbladder and the pyloric portion of the stomach. A calculus about 1.5 cm. in diameter was located in a small cystic cavity of the stomach wall completely separated from the lumen of the viscus.

According to Murphy, ileus due to gallstone which has perforated through the gallbladder into the intestine may have no preceding jaundice, but the inflammatory symptoms which accompany such a perforation ought to suggest the diagnosis.

Three of the four cases presented by Powers showed symptoms characteristic of the type of indigestion which so frequently accompanies disease of the biliary system. The clinical picture is that of sudden acute intestinal obstruction or recurrent attacks of partial obstruction. Visible peristalsis is rarely present, he finds, and local tenderness, as a rule, is not marked: sensitiveness beneath the right costal margin in the region of the gallbladder offers a valuable diagnostic clue in cases of recent perforation. Generalized abdominal spasm is indicative of general peritonitis.

The process by which the stone reaches the intestinal tract begins, says Jackson, as cholecystitis and cholelithiasis, followed by erosion, ulceration, and pericholecystitis, with the formation of adhesions between the gallbladder or ducts and the surrounding viscera. Perforation occurs within the adhesions.

The impaction of a gallstone as a cause of intestinal obstruction has long been recognized. It is the rarest of all forms of intestinal obstruction. An early, correct diagnosis has seldom been made. As a result, the patient is not sent to the hospital until in a dangerous condition. Wakeley and Willway state that: "Most stones entering the intestinal tract are passed naturally, with no symptoms except the initial attack of biliary colic. Stones which are large enough to cause obstruction never pass the entire length of the common bile duct, but ulcerate through from the gallbladder into the bowel." In cases in which intestinal obstruction has been produced by gallstones, the stone, or stones, usually have passed through fistula. Not infrequently, a large stone has been found in the intestinal tract without having produced any untoward symptoms.

The records relative to the frequency of intestinal obstruction due to gallstones apparently vary rather widely. Osler reported twenty-three cases due to gallstones out of a total of 295, or 7.8 per cent. Vick, in a symposium on intestinal obstruction, in 1932, reported forty-seven out of 3,625 cases, or 1.3 per cent. Combining the statistics which we have gathered from various authors, it is found that out of a total of 7,232 cases of intestinal obstruction, 149 were due to gallstones, or two per cent of all obstructions. The mortality is in the neighborhood of fifty per cent and is largely the result of delay. The history is not typical of intestinal obstruction and the true diagnosis is difficult. We have records of forty cases of complete, or partial, obstruction of the bowel during the past three years; two cases, or about five per cent, were due to gallstone impaction. The average age of all cases reviewed was sixty-six years; eighty per cent were females.

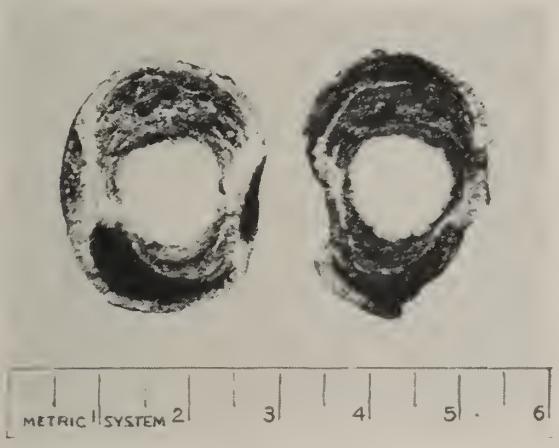
The estimation of the frequency of the occurrence of gallstone ileus is now practically impossible. Wagner found that 334 cases had been recorded in the literautre prior to 1914. In 1925, Moore estimated that 400 cases had been recorded. At the Mayo Clinic it was observed, ten cases of intestinal obstruction was proved to be the result of gallstones. In these cases the obstruction was produced in one of three ways: (1) the stone was too large to pass through the lumen of the intestine; (2) the stone produced intussusception; or (3) the stone became embedded in the wall of the intestine and closed its lumen. In all of these cases it is probable that the stone, or stones, were too large to pass through the lumen of the intestine and that the intussusception of the inflammatory mass was a secondary reaction.

In practically every case in which the location of the obstruction was mentioned, it was within two feet of the ileocecal valve, most frequently about twelve inches from the cecum. In a large percentage of cases, the history of obstruction is intermittent. In most there was an antecedent history suggesting gallstone colic, often several years previously, then recurrent attacks of so-called indigestion with distention, nausea and vomiting, with severe cramp-like pains, which frequently ceased as suddenly as they had begun. The most common diagnosis was food poisoning. In many cases the history was vague, consisting of the occurrence of chills and fever, suggesting an infected gallbladder. After recovery from this, there followed recurrent headaches with vague abdominal pain, nausea and vomiting. These episodes were usually diagnosed as migraine. After a period of from three to fifteen years with symptoms suggestive of gallbladder disease, a complete obstruction of the bowel occurred. From the histories reviewed one would gather that the obstruction was incomplete at first. Relief is afforded by the stone moving back into a larger segment of the intestine by retroperistalsis. Finally, the stone is propelled into the narrow part of the ileum and becomes lodged. If recognized early, the operative removal of the stone is comparatively simple.

The stone finds entrance to the intestines by ulcerating through the gallbladder wall into some part of the intestinal tract, most frequently into the duodenum. Usually a short fistulous tract is found; sometimes there is a direct opening. The findings at autopsy, as reported by Courvoisier is thirty-six cases, are of interest in this connection. The fistula entered the duodenum in twenty-five instances, the ileum in one, into both the colon and duodenum in two, the colon in one, and no fistula was demonstrable in seven cases. In most instances a dense mass of adhesions firmly bound the gallbladder and duodenum together, enclosing a cystoduodenal fistula. Of the 149 cases of internal biliary fistulae reported

in the literature, the gallbladder was always involved. Therefore, while in theory a stone may ulcerate through the common duct into the intestine, not one case was found recorded. Every internal biliary fistula found was from the gallbladder to some part of the intestinal tract.

Bernhard reported finding 109 internal biliary fistulae in 6,263 cases of surgical intervention upon the biliary passages, or 1.8 per cent. The gallbladder opened into the duodenum in fifty-six instances, into the colon in thirty-six, into the stomach in twelve and into several fistulous tracts in five.



The above cut shows the transverse diameter (three centimeters) of the cholesterin stone removed from the case herein reported.

There is a general impression that life expectancy is rather short after an internal biliary fistula has been established. This is largely due to the fact that in dogs an ascending infection through the bile passages occurs and death follows rather early. We may seriously question the truth of this observation as applied to man, if one reviews the statistics.

We have found records of two cases which have survived gallstone obstruction of the bowel, and lived with an internal biliary fistula for fifteen and nineteen years, respectively, in normal health. In addition there are two others, with autopsy findings, which occurred on the service of two confreres on the staff of St. Vincent's Hospital. In all four of these cases the fistula was from the gallbladder to the duodenum. In each instance the obstruction was within two feet of the ileocecal valve.

Dr. J. S. Stell, of Hot Springs, reports a case of a stone, near the ileocecal valve, which had caused obstruction. This patient was seventy-two years old, and died shortly after operation. The autopsy did not reveal any evidence as to the source of this stone. The patient had had three previous attacks of gallstone colic and the stone was pocketed in a diverticulum of the small intestine. In our review of the literature no report of a casein stone was found. He states that the analysis of the stone did not show cholesterin, and only a trace of bile salts. The intestinal origin from the caseins of ingested food seem more likely than its formation in the biliary tract.

Gracomelli reports a case of perforation of the colon by a Fecolith, while Stulz describes an instance of intestinal occlusion, due to the same cause.

CASE REPORT

Mrs. A. H. Housekeeper — age forty-eight — married. Family History—Father dead at thirty-eight, appendicitis. Mother dead at sixty-seven, appoplexy. Two brothers living, one age fifty-eight, health good, one age forty-eight, has some form of stomach and kidney trouble. No brothers dead. Two sisters dead, one at age of seven, scarlet fever, one at age of twenty-eight, childbirth—forceps delivery—died fourteenth day after delivery. No history of hereditary diseases could be elicited in remainder of the family.

Past History—Diseases of childhood, influenza in 1918, severe, recovery. Appendectomy twenty-five years ago, recovery. Has had four children, all instrumental delivery except one. Youngest now twelve years old. Otherwise, personal history negative.

Present Ailment—Has had periodic pain in upper right quadrant for the past fourteen years. Gradually became worse and more frequent. The duration of the attacks somewhat short, none of which lasted more than twenty-four hours. Very much exhausted after attacks. At times could feel considerable lump in the side during the attacks. I saw her at her home first on February 1, 1940. She was suffering from a severe cramping pain in the upper right quadrant. There was considerable tenderness and rigidity of the abdominal muscles. She was nauseated, but did not vomit. I advised her to go to the hospital, but she declined. She reported at my office on February 15, suffering with symptoms similar to those described above, but not quite so severe.

Physical Examination—Temperature 98.6, pulse seventy-two, respiration eighteen, blood pressure 120-70, height five feet three and one-half inches, weight 200 pounds. Skin, mucous membrane, eyes, ears, nose, mouth, neck, chest, lungs, heart, rectum, extremeties, negative. Definite pain on palpation over gallbladder region. Somewhat nauseated and considerable gas in stomach, but abdomen otherwise normal. Perineal tear moderate in degree. Uterus normal, but slightly prolapsed. Cystocele moderate degree. No varicosities. Patient very obese. Patient was again advised to go to hospital for gallbladder operation, but declined.

(Continued on Page 58)

President's Page

NATIONAL PHYSICIANS COMMITTEE

To the Members of The Kansas Medical Society:

In a previous President's Page I have asked Kansas doctors to support the National Physicians Committee and its activities. At this time I wish to make some suggestions to this Committee for further increasing its activities.

The N.P.C. has its office in Chicago and its general plan of operation has been an educational campaign to acquaint the public with the problems of medical care and to promote education of our legislators in Washington on medical problems through contact by physicians at home with these legislators. This is a good program if carried out correctly with an understanding that our actual voting power is small and that results can be obtained only by informing the legislators of the true problems involved in medical legislation.

However, I feel that this is only one-half of the job that this Committee should do. The other half is equally important and probably more effective, and that consists of establishing the main office of the Committee, or a second Committee office, permanently in Washington, D. C. The staff of this office should spend a large portion of its time in calling upon and visiting with the legislators and with the officials of governmental agencies in Washington in an effort to make friends for medicine and to bring more first-hand information to these individuals upon the problems of medical care. Much aid could be given to the legislators and these agencies in their studies of medical problems and with that aid would go their education in the fundamentals of medicine. This office could assist them and cooperate with them in their studies of problems pertaining to medicine that are brought to them and could bring about a better understanding between the medical profession and these legislators and governmental agencies.

This closer integration of the medical profession with the legislators in Washington and with the governmental bureaus in Washington is absolutely necessary if medicine is to have its rightful place in guiding the course of Federal medical legislation into those channels which will mean an ever-improving medical care of the public. **The N.P.C. will only be doing a half-job until it establishes a permanent office with the proper personnel in Washington, D. C.**

Sincerely,

Henry N. Ickes, M. D.

President, The Kansas Medical Society.

EDITORIAL

ANNUAL SESSION

In view of the present war time situation it has been the decision of the Society Council that there will be no regular annual session with scientific meetings and exhibits, and that only a business meeting will be held. Although the time has not as yet been set it is believed the meeting will be held during the first half of May.

The House of Delegates, Council, officers and any committee chairmen who have matters which should be brought before the House of Delegates will attend the meeting. There will be two sessions of the House of Delegates, the first to be held on Saturday evening and the second on Sunday morning. As usual the Council meeting will follow immediately after the second session of the House of Delegates. The election of officers will be held at the second session of the House of Delegates, or on Sunday morning.

It is expected in the present emergency, because of transportation difficulties, that most of the other states will also cancel their general sessions, and substitute the absolutely necessary business meeting. Some few of the state organizations are holding one day scientific sessions and it is the general understanding that many of the regional clinics will hold their usual meetings.

Kansas has made this decision reluctantly and only after mature consideration. Our doctors are needed at home to care for civilian needs.

DEATH OF TWELFTH DISTRICT COUNCILOR

The death of Dr. Geo. O. Speirs of Spearville, on January 28, is a great loss to the Society. Dr. Speirs has been active in Society work for many years, having held the position of President of the Ford County Medical Society, serving on numerous committees, and was Councilor for the Twelfth District in 1937, which position he held at the time of his death as well as that of Secretary of the Ford County Medical Society.

Besides his many professional activities he was considered by his town "our No. 1 citizen" according to the editor of the Spearville News. His son, Major Richard Speirs, is now serving in the medical corps of the United States Army.

THE ONE-DAY CURE FOR SYPHILIS

"It is surprising that the Reader's Digest, which renders a notable service with its excellent summaries of current magazine articles and new books, should publish for lay consumption an article (de Kruif, P. Found: a one-day cure for syphilis. Reader's Digest, September, 1942.) on a new one-day cure for syphilis as if the procedure were already available for every physician to use as safe and scientific on any and all patients with syphilis.

"Such an ill-advised statement has raised many false hopes and disturbed many patients who are progressing satisfactorily under treatment. It has instigated many queries to physicians and medical journals about a method that is still in the experimental stages. The method has very definite hazards. Not everyone can tolerate a fever of 106 degrees F., and patients with certain defects should never be exposed to such a temperature. The apparatus and controls are not at hand. Neither physicians nor nurses have had sufficient training in the method. Too few cases have been treated and too short a time has elapsed to know if there are any late serious effects of the treatment and if the results on the disease are permanent. It may be a step forward in the treatment of syphilis, but much experimental work must be done to be sure that this particular technic is the proper procedure for every case of syphilis. There are many pitfalls in this complicated program, and it is cruel for a scientifically trained writer to propose such a method to the public as accepted and readily available in every city and town. Furthermore, why did this writer pick out an eleven-year-old article to stress the bad effects of routine anti-syphilitic treatment? In a letter published in the September 19 issue of the Journal of the American Medical Association, Dr. Harold N. Cole, a distinguished syphilographer and the author of the former article, emphasizes the bad effects of publicizing prematurely an experimental procedure that needs confirmation before it is widely available for syphilis in general.

"Physicians can assure their questioning patients that the one-day treatment is in the experimental stage and is not a safe and sure procedure and that it will eventually be made readily available if scientific evidence warrants its acceptance. Incidentally, one cannot refrain from suggesting that the publication of medical articles in a periodical for lay consumption is a great responsibility and one that cannot be discharged properly without the aid of competent medical opinion."—From the New England Journal of Medicine.

M. V's.

A group of busy men, under the leadership of Frederick D. Grave of New Haven, Connecticut, organized a Men's Volunteer Corps in December of 1942, to give part time assistance at a New Haven hospital. The hospital, because of the war emergency, had lost not only doctors and nurses but also medical assistants.

The M.V's. as they are called now number seventy-five, and the new volunteer idea has assisted materially in solving the problem of the decreasing hospital personnel. The group are all busy men from all occupations who can still find time to work a few hours a day or night in the hospital.

The M.V's. wear blue service coats with a special insignia sewn on them. They assist in professional care, property care and nursing. The professional care consists of nursing service, dietary service, technical (laboratory) service and special projects. The property care is divided into such tasks as assisting with housekeeping functions, operating elevators and other tasks. Operations work includes many clerical and administrative type assignments.

The volunteer group is a new addition to the other fine products of the war, namely, the Red Cross Nurses' Aides and the Grey Ladies. Many other towns could organize similar groups to assist hospitals in a like situation.

MEDICAL CARE PLANS

"During the State Secretaries' Annual Meeting at American Medical Association headquarters in Chicago November 20 and 21, nearly a half day was devoted to a discussion of Medical Care Plans now in operation in several states, notably Michigan, Massachusetts, and California.

"These plans of medical care insurance embrace in one state families whose income is $3,000.00 and in the other two states $2,500.00.

"Apparently a majority of physicians in those states who affiliate with their State Medical Societies have signified approval of the plan and a willingness to participate in its benefits.

"A representative of the American Medical Association Bureau of Medical Economics outlined the problems arising from the Farm Security Association program of Farm Medical Care.

"It is quite apparent that programs of medical care approved by the American Medical Association and functioning through State Medical Societies have not as yet attained perfection anywhere. However, directors of these activities are weeding out the faults from their plans and adding elements of security both to recipients of the proposed care and those who administer the service.

"Members of organized medicine may well afford to undertake a careful study of these plans for medical care insurance which are making rapid progress in other states.

"Unless organized medicine provides the type of medical care of its own volition the whole program will eventually be throw in their faces by national legislation.

"A study of recent political trends appears to be more favorable toward medical legislation which has been approved by the medical profession as a whole.

"New problems and new solutions will follow in the aftermath of the war and we should be prepared to meet them logically and equitably to all concerned.

"A host of unassigned physicians in the prime of life and fully prepared and qualified to practice medicine in any of its varied services will come back to us like an avalanche when the army is mustered out.

"New avenues of service such as largely increased public health service personnel will take care of some of them, a large number will be retained in the army but places must be found for all.

"Unless we prepare in advance to take care of our war physicians, as well as the host of men returning from the ranks, the picture of medical practice in the future may be drawn on a national basis by those whose ideas are inimical to present methods of practice."—M. C. K.—From the Rocky Mountain Medical Journal.

TUBERCULOSIS CONTROL

HAEMORRHAGE FROM THE TRACHEA, BRONCHI, AND LUNGS, OF NONTUBERCULOUS ORIGIN

The spitting of blood is, of course, the presenting symptom in many and diverse conditions, so the need for painstaking detailed diagnostic study cannot be stressed too strongly. Short cuts and diagnoses by inference are to be condemned.

First, it is necessary to eliminate haematemesis. Useful here is the fact that blood from the lower respiratory tract is usually frothy, bright red in color, and apt to be mixed with bronchial secretion, while that from the stomach ordinarily is dark and often contains particles of food. It should also be noted

that in cases of massive haemorrhage, pallor and loss of consciousness are likely to precede a haematemesis while in bronchopulmonary bleeding the blood almost invariably is expectorated before signs of actual blood loss appear.

Having by history and careful physical examination eliminated haematemesis, and obvious lesions of the larynx and nasal, oral or pharyngeal cavities, it must be assumed that the source of the blood subglottic. It is important to note here that the authors believe that, "Far too much emphasis has been placed upon varicose veins at the base of the tongue as haemorrhagic foci." (Not a single case was found in their series.)

Now having determined that the blood is coming from the lower respiratory tract, tuberculosis is the most likely diagnosis and to quote the authors, "The disease masquerades under many and varied guises." The inquiry must be considered incomplete until the tuberculous or nontuberculous nature of the underlying lesion has been established beyond question.

Tuberculosis being ruled out and cardiovascular disease, the blood dyscrasias, and acute lobar pneumonia eliminated, the search becomes more difficult.

Precise localization and identification of the causative lesion are dependent upon supplementary procedures. A comprehensive fluoroscopic and roentgenographic examination of the chest, including planigraphy and bronchography when indicated, is in order in every case of haemoptysis and bronchoscopy if necessary. As to the advisability of bronchoscopying a patient during or immediately following a haemorrhage, the authors believe that streaking of the sputum is not a contraindication, but that where frank haemoptysis occurs, bronchoscopy should not be performed until several days have elapsed since its cessation.

What now are the aetiological probabilities? The authors indicate them in the following table, which shows the results of careful diagnostic study of 436 patients referred for bronchoscopy. In the interpretation of this table, it is important to note as the authors point out that, "A great many patients admitted to the hospital with pulmonary bleeding are not seen by the bronchoscopist, the nature of the underlying disease being such that no indication for the direct inspection of the tracheobronchial tree is present. Included in this category are patients with cardiovascular lesions which lead to the production of chronic passive congestion or pulmonary infarction, patients with acute lobar pneumonia, and patients with blood dyscrasias. This group observed by the internist alone, represents a considerable number of patients with haemoptysis."

Noteworthy are the authors' comments that: (1) "Inflammatory processes are responsible for the haemorrhage in the majority of the cases, the most common aetiological agent being bronchiectasis." (2) "Taking into consideration the fact that expectoration of blood is the initial manifestation of carcinoma of the bronchus in only a very small percentage of the patients, it is obvious that bronchoscopy must be done and the diagnosis made early in the course of the disease, before the symptoms have reached the stage of haemorrhage, if a successful therapeutic result is to be achieved in these cases." (3) "Fatal haemorrhage occured in but three of the patients in the series, each of whom had a pulmonary abscess."—From Tuberculosis Abstracts —February, 1943.—Haemorrhage from the Trachea, Bronchi and Lungs of Nontuberculous Origin. Chevalier L. Jackson and Sidney Diamond, Amer. Review of Tuber., August, 1942.

TRACHEAL, BRONCHIAL AND PULMONARY LESIONS FOUND IN 436 PATIENTS HAEMOPTYSIS

NATURE OF LESION	Number of Patients in Each Age Group at Time of Initial Haemoptysis							Total Number of Patients
	Less than 10 years	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	More than 60 years	
Bronchiectasis	19	25	38	19	20	15	2	138
Primary carcinoma of bronchus		1	3	9	20	34	15	82
Tracheobronchitis	4	2	21	12	12	15	8	74
Pulmonary abscess		4	15	16	9	5	2	51
No evidence of disease		2	10	14	5	3		34
Nonsuppurative pneumonitis	2		3	5	3	1	1	15
Suppurative pneumonitis		1	4	1	2	3		11
Adenoma of bronchus		3	3	3	2			11
Secondary cancer of lung				1	1	2	2	6
Lobar atelectasis		2			1	1		4
Primary carcinoma of trachea					1	1		2
Suppurating pneumoconiotic lymph node discharging into bronchus							1	1
Nonspecific granuloma of bronchus				1				1
Streptothricosis						1		1
Chondroma of bronchus						1		1
Osteoma of trachea							1	1
Dermoid cyst communicating with bronchus				1				1
Broncholithiasis							1	1
Neurofibroma involving wall of bronchus		1						1
Totals	25	41	97	82	76	82	33	436

A reasonably safe wager would be that one could approach any college president in the United States, and, with a minimum of sales talk, sell him a fistful of Christmas Seals. The hitch comes when we try to sell many of these leaders the very program their own money has gone to support. It is to be feared that sometimes we contribute to worthy causes in order to be spared further thought about them or contact with their unpleasant realities. Too many college administrators, even in these enlightened days, refuse to admit the necessity for early diagnosis among their own students, though they will give generously to an agency whose chief concern is early diagnosis for all who need it. —Charles A. Lyght, M.D., Journal-Lancet.

Buy United States War Bonds and Stamps

NEWS NOTES

84TH ANNUAL SESSION

The Council has recently announced that the 84th Annual Session of The Kansas Medical Society will be only a business meeting instead of the usual scientific, technical and business session combined. Although the exact date of the business meeting has not been set, it is believed that it will be held during the first half of May on a Saturday and Sunday.

LEGISLATIVE MEASURES

In addition to the osteopathic bill, (House Bill No. 40) which is printed in full in this issue of the Journal, other measures which may be of special interest to the profession that have been introduced in the 1943 session of the Kansas Legislature are briefly as follows:

House Bill No. 25. An Act providing for the temporary registration of nurses in this state to protect the health of the civilian population during the present war emergency, has passed the House and is now in the Senate.

House Bill No. 91. An Act in relation to consulting psychologist, creating a board of examiners, prescribing certain powers and duties, and providing penalties for violations of this act, was on General Orders on February 12.

House Bill No. 121. An Act relating to the examination and registration of doctors of medicine or surgery and the state board of medical registration and examination, amending sections 65-1001 and 74-1001 of the General Statutes of 1935, and repealing said original sections, has passed the House and is now in the Senate Committee.

House Bill No. 138. An Act relating to public health, providing prenatal serological tests for syphilis, and prescribing certain powers and duties, was on General Orders of the House on February 12.

House Bill No. 139. An Act relating to marriage, providing examinations and seriological tests of applicants for marriage license, and providing penalties. The bill is still in Committee.

Senate Bill No. 81. Same as House Bill No. 92.

Senate Bill No. 93. Same as House Bill No. 121.

Senate Bill No. 94. Same as House Bill No. 120.

House Bill No. 120 is of particular interest to the medical profession now in the armed service and is therefore published in full below:

"AN ACT relating to persons who at the time of their entrance into the military service were registered or licensed to engage in or practice an occupation or profession in the state of Kansas, and providing that such licensees and registrants shall not be required to pay certain annual fees to the state of Kansas.

"*Be it enacted by the Legislature of the State of Kansas*:

"Section 1. As used in this act, the following terms shall have the meanings ascribed to them by this section, unless the context clearly requires otherwise: (1) "Military service"' means service by a licensee in the army, navy or marine corps of the United States and shall also include the six months period of time immediately following his discharge therefrom. (2) "License" means any permit, certificate, authority, privilege or registration issued, granted or made by the state of Kansas or any officer, board, department or commission thereof authorizing a person to engage in or practice an occupation or profession in this state. (3) "Licensee" means any person who had, at the time of his entering the military service, a valid, existing license to engage in or practice an occupation or profession in this state.

"SEC. 2. The provisions of any law relating to the licensing of persons engaged in or practicing an occupation or profession which require the payment of an annual license fee shall be construed to be inapplicable to a licensee in the military service and no license shall be required to pay an annual license fee accruing while such licensee is in the military service except as provided in section 3 hereof. No license of any licensee shall be revoked or suspended because of the nonpayment, during the period of his military service, of an annual fee.

"SEC. 3. A licensee, who desires to engage in or practice his occupation or profession in this state after his discharge from the military service, shall, within six months after such discharge, pay the annual fee required by law for such year and thereupon, he shall be deemed to have complied with all requirements of law relating to the payment of annual fees.

"SEC. 4. The provisions of this act shall apply to all licensees who enter the military service on or after December 23, 1940, and shall not apply to licensees who during the period of such service are engaged in or practicing an occupation or profession in this state, either personally, or indirectly by agent. If the license of any such licensee has been suspended or revoked prior to the effective date of this act solely because of the failure of such licensee to pay annual fees, accruing during such service, such suspension or revocation is hereby set aside and canceled.

"SEC. 5. This act shall be construed as supplemental to and not as repealing any existing law.

"SEC. 6. This act shall take effect and be in force from and after its publication in the official state paper."

AMA HOUSE OF DELEGATES MEETING JUNE 7

The House of Delegates of the American Medical Association will convene in Chicago on June 7. Due to its cancellation, this meeting will take the place of the ninety-fourth annual session, which had originally been scheduled to be held in San Francisco.

According to the Journal of the American Medical Association this is the third time sessions have been cancelled, the other two times being in 1861 and 1862 during the Civil War.

Significant problems which will be discussed at the House of Delegates Meeting will be: provision and distribution of physicians, provision of medical services for the nation's civilian and military needs as well as the usual business matters of the organization.

CONGRESS ON MEDICAL EDUCATION AND LICENSURE

The Thirty-ninth Annual Congress on Medical Education and Licensure was held in Chicago at the Palmer House on February 15 and 16.

The following is a list of the program and speakers:

Education and the War—Edward C. Elliott, Washington, D.C., Chief, Professional and Technical Employment and Training Div. of the War Manpower Commission.

Premedical and Medical Education as Related to the U. S. Army—Brig. Gen. Joseph N. Dalton, Washington, D. C., Assistant Chief of Staff for Personnel, U. S. Army.

Medical Education as Related to the Procurement and Assignment Service—Harold S. Diehl, M.D., Minneapolis. Member of the Directing Board of the Procurement and Assignment Service for Physicians.

Graduate Education and the War—Donald C. Balfour, M.D., Rochester, Minn. Director, Mayo Foundation for Medical Education and Research.

Medicine and the War—Col. George F. Lull, M.D., Washington, D. C., Chief Personnel Division U. S. Army Medical Corps.

Rear Admiral Ross T. McIntire, M.D., Washington, D.C., Surgeon General U. S. Navy.

Thomas Parran, M.D., Washington, D. C., The Surgeon General, U. S. Public Health Service.

Medical Licensure and Civilian Medical Needs—Harvey B. Stone, M.D., Baltimore. Member directing board of the Procurement and Assignment.

Mobilization of Canada's Health Resources for War.—Thomas C. Routley, M.D., Toronto, Ontario. Gen. Sec. Canadian Medical Association.

Medical Licensure in New York State—Robert R. Hannon, M.D., Albany, N. Y., Secretary of the New York State Board of Medical Examiners.

Medical Licensure and Public Health—Felix J. Underwood, M.D., Jackson, Miss., President-Elect of the American Public Health Association and Secretary of the Misssissippi State Board of Health.

Necessary Legislation for Graduates of Accelerated Medical Courses and Temporary Interstate Relocation of Physicians—J. W. Holloway, Jr., Chicago, Director of the Bureau of Legal Medicine and Legislation of the American Medical Association.

Basis Science Laws, Board of Practices in the United States—Orin E. Madison, Ph.D., Detroit, President of the Michigan State Board of Examiners in the Basic Sciences.

Present Day Difficulties of Medical Practice and Licensure—Adam P. Leighton, M.D., Portland, Maine, Secretary of the Maine Board of Registration of Medicine.

Uniform Interstate Endorsement as a War Emergency Measure—General Discussion opened by—J. Earl McIntyre, M.D., Lansing, Mich. Secretary of the Michigan Board of Registration in Medicine.

Medical Schools in Wartime—Willard C. Rappleye, M.D., New York, Dean of the Columbia University College of Physicians and Surgeons.

Presidential Address—Julian F. Du Bois, M.D., St. Paul, Secretary of the Minnesota State Board of Medical Examination.

The National War Nursing Program—Miss Alma C. Haupt, R.N., Washington, D.C., Executive Secretary, Subcommittee on Nursing of the Health and Medical Committee, Defense, Health and Welfare Service.

HOUSE BILL NO. 40

The osteopaths have again introduced a proposal in the Kansas Legislature to broaden their rights of practice and to permit them to practice medicine and surgery. The bill was introduced by Representative Will R. Christian of Ulysses (Grant County) and Representative K. A. Bush an osteopath of Harper. Bush and Representative I. E. Nickell of Smith Center another osteopath are both members of the House Committee on Hygiene and Public Health. There are no doctors of medicine in the House of Representatives this session.

In the bill which follows the italics are the new parts of the bill and the words which are in parenthesis are those that will be deleted from the bill:

AN ACT relating to the practice of medicine and surgery, creating a state board of physicians and surgeons registration and examination, abolishing the state board of medical registration and examination and the state board of osteopathic examination and registration, and amending sections 65-1001, 65-1003, 65-1005, 65-1006 and 65-1008 of the General Statutes of 1935, and repealing said original sections and also repealing sections 65-1002, 65-1201, 65-1202, 65-1203, 65-1204, 65-1205, 65-1206, 74-1001 and 74-1201 of the General Statutes of 1935, and sections 65-1207 and 65-1208 of the General Statutes Supplement of 1941.

Be it enacted by the Legislature of the State of Kansas:

SECTION 1. There is hereby created a state board of physicians and surgeons registration and examination. The board shall consist of seven members to be appointed by the governor by and with the consent of the senate upon the taking effect of this act. One member shall be appointed for a term of one year; two members for a term of two years; two members for a term of three years and two members for a term of four years, and the successors of each shall be appointed in the same manner for the term of four years. The members of the board shall be physicians in good standing in their profession, and who shall have received the degree of doctor of medicine or doctor of osteopathy from some reputable medical college or university or college of osteopathy not less than six years prior to their appointment; representation to be given to the different schools of practice as nearly as possible in proportion to their numerical strength in this state: *Provided,* There shall be at least two representatives of the osteopathic school of practice upon such board at all times. Before the governor shall appoint a member to the board as a representative of any particular school of practice, the regular state association or society for such school of practice shall submit to the governor a list of five persons qualified for membership on the board, and the governor shall make his appointment from such list. Each member of the board shall take and subscribe the oath prescribed by law for state officers, which oath shall be filed with the secretary of state. The board shall organize by the selection of a president and secretary from among their own number, each to serve for such term as the board may designate, not exceeding four years. It shall have a common seal, and shall formulate rules to govern its actions. Its president and secretary shall have power to administer oaths pertaining to all matters relating to the business of the board. The secretary shall be the custodian of the common seal and of the books and records of the board and he shall furnish to said board a satisfactory bond, conditioned for the faithful performance of his official duties. Said board shall hold regular meetings on the third Tuesday in June and the second Tuesday in December, at such time and place as the board may designate in such of the chief cities of the state as the board may designate. Five members shall constitute a quorum for the transaction of all business; but no license to practice medicine and/or surgery shall be issued by the board upon less than five affirmative votes when the full board is present, or upon less than a majority affirmitive vote when less than a full board is present. The board shall keep a record of all its proceedings, and also a register of all applicants for license to practice medicine in all of its branches within

the state, together with a record showing the age of the applicant, time spent in the study of medicine, and the name and location of the institution or institutions from which the applicant may have received degrees or certificates of medical instructions; also, whether the applicant was licensed or rejected. Said books and register shall be prima facie evidence of all matters recorded therein.

SEC. 2. The state board of medical registration and examination as created by section 74-1001 of the General Statutes of 1935, and the state board of osteopathic examination and registration as created by section 74-1201 of the General Statutes of 1935, are hereby abolished.

SEC. 3. Section 65-1001 of the General Statutes of 1935 is hereby amended to read as follows: Sec. 65-1001. All persons intending to practice medicine or surgery after the passage of this act, and all persons who shall not have complied with section 2 of this act, shall apply to said board at any regular meeting or at any other time or place as may be designated by the board for a license. Applications shall be made in writing and shall be accompanied by the fee hereinafter specified, together with the age and residence of the applicant, proof that he is of good moral character and satisfactory evidence that he has devoted not less than three periods of six months each, (no two within the same twelve months,) or if after April 1, 1902, four periods of not less than six months each, (no two within the same twelve months,) to the study of medicine and surgery. All such applicants, except as hereinafter provided, shall submit to an examination of a character to test their qualifications as practioners of medicine or surgery, and which shall embrace all those topics and subjects a knowledge of which is generally required by reputable medical colleges of the United States for the degree of doctor of medicine, *and in addition thereto, all applicants, except as hereinafter provided, intending to practice as osteopathic physicians and surgeons shall submit to an examination of a character to test their qualifications as practitioners of osteopathy, which examination shall embrace all additional topics, a knowledge of which is generally required by reputable osteopathic colleges of the United States for the degree of doctor of osteopathy*: *Provided,* That (the) *any* examination in materia medica and therapeutics and in the theory and practice of medicine *which shall be given* shall be conducted by those members only of the board who are of the same school of practice as the applicant claims to follow: *Provided further,* That graduates of legally chartered medical *or osteopathic* institutions of the United States or foreign countries in good standing, as determined by the board, or persons holding the certificate of the national board of medical examiners of the United States of America, *or national board of examiners for osteopathic physicians and surgeons,* may be, at the discretion of the board, granted a license without examination: *Provided further,* That the board may in its discretion accept, in lieu of examination or diploma the certificate of the board of registration and examination of any other state or territory of the United States or any foreign country whose standards or qualification for practice are (equivalent to) *not less than* those of this state. The board may refuse to grant a certificate to any person guilty of felony or gross immorality or addicted to the liquor or drug habit to such a degree as to render him unfit to practice medicine or surgery, and may, after notice and hearing, revoke the certificate for like cause, or for malpractice or unprofessional conduct.

SEC. 4. All persons at the time of the passage of this act licensed to practice medicine and surgery in the state of Kansas or licensed to practice osteopathy in the state of Kansas shall receive the certificate provided in section 65-1003 of the General Statutes of 1935, as amended without examination, upon supplying evidence of such previous licensure to the board: *Provided, however,* That graduates of osteopathic colleges who have heretofore been granted a license to practice osteopathy in the state of Kansas, or who may hereafter be granted the certificate provided for in said section 65-1003, shall have the right to practice major surgery, only upon presenting evidence satisfactory to the board of at least (*a*) one year's internship and one year's assistantship in a hospital subsequent to graduation from an osteopathic college, or (*b*) two year's assistantship in major surgery, or (*c*) the practice of major surgery for at least five years.

SEC. 5. Section 65-1003 of the General Statutes of 1935 is hereby amended to read as follows: Sec. 65-1003. Upon the completion of the examination or the acceptance of the diploma or certificate as herein provided, the said board shall, if it finds the applicant qualified, grant and issue a certificate to said applicant to practice medicine and surgery within this state, and which will be signed by the president and secretary and attested to by the seal of the board. *All such applicants who are thus granted a certificate to practice medicine and surgery shall have equal rights (regardless of their school of practice) with respect to the treatment of cases, the holding of public office or office in public institutions and practice in hospitals and other public institutions and with respect to rendering service under the provisions of public health and public welfare laws including, without limiting the generality of the foregoing, laws concerning health insurance, workmen's compensation, control of infectious diseases and care of the indigent.* Within thirty days of the date of any certificate of license having been granted and issued by the board, the owner thereof shall have it recorded as hereinafter provided in the office of the clerk of the county in which he resides, or, if a nonresident of the state, then of the county in which he has an office or intends to practice, and the date of recording shall be endorsed thereon; and until such certificate of license is recorded he shall not exercise any of the rights or privileges therein conferred. The county clerk shall keep in a book for that purpose a complete list of the certificates recorded by him, which book shall be open to public inspection during business hours. Between the first and twentieth days of December in each year, the county clerk shall furnish the secretary of the board a list of all certificates recorded in force, and also a list of all certificates which have been revoked or the owners of which have removed from the county or died during the year. The fee for the recording and reporting of such certificates shall not exceed one dollar.

SEC. 6. Section 65-1005 of the General Statutes of 1935 is hereby amended to read as follows: Sec. 65-1005. Any person shall be regarded as practicing medicine and surgery within the meaning of this act who shall prescribe, or who shall recommend for a fee, for like use, any drug or medicine, or perform any surgical operation of whatsoever nature for the cure or relief of any wounds, fracture or bodily injury, infirmity or disease of another person, or who shall use the words or letters "Dr.," "Doctor," "M.D..," "D.O." or any other title, in connection with his name, which in any way represents him as engaged in the practice of medicine and surgery, or any person attempting to treat the sick or others afflicted with bodily or mental infirmities, or any person representing or advertising himself by any means or through any medium whatsoever or in any

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manner whatsoever, so as to indicate that he is authorized to or does practice medicine or surgery in this state, or that he is authorized to or does treat the sick or other afflicted with bodily infirmities, but nothing in this act shall be construed as interfering with any religious beliefs in the treatment of diseases: *Provided,* That quarantine regulations relating to contagious diseases are not infringed upon. This act shall not apply to (any registered osteopathic physician or) any chiropractic practioners of the state of Kansas, or any commissioned medical officer of the United States army, navy or marine service in the discharge of his official duties; nor to any legally qualified dentist, when engaged in the legitimate practice of his profession; nor to any physician or surgeon who is called from another state or territory in consultation with a licensed physician of this state, or to treat a particular case in conjunction with a licensed practitioner of this state, and who does not otherwise practice in the state. Nor shall anything in this act apply to the administration of domestic medicines, nor to prohibit gratuitous services: *Provided,* Any person holding a diploma issued by an optical college, and who has studied anatomy of the eye and contiguous parts, human physiology and natural philosophy for at least six months under a competent teacher, and who shall pass examination satisfactorily to the state board of medical registration and examination, shall be eligible to register as an optician or doctor of optics, and shall be otherwise governed by this act so far as the same is applicable.

SEC. 7. Section 65-1006 of the General Statutes of 1935 is hereby amended to read as follows: Sec. 65-1006. (From and after the 1st day of September, 1901,) Any person who shall practice medicine and surgery in the state of Kansas without having received and had recorded a certificate under the provisions of this act, or any person violating any of the provisions of this act, shall be deemed guilty of a misdemeanor, and upon conviction thereof shall pay a fine of not less than fifty dollars nor more than two hundred dollars for each offense; and in no case wherein this act shall have been violated shall any person so violating receive compensation for services rendered. It shall be the duty of the secretary of the state board of registration and examination to see that this act is enforced.

SEC. 8. Section 65-1008 of the General Statutes of 1935 is hereby amended to read as follows: Sec. 65-1008. That the secretary of the state board of physicians and surgeons registration and examination may in his discretion issue a temporary permit to practice medicine, or surgery to any person who shall have made application in writing to said board for license to practice, accompanied by the prescribed fee, and proof as required by section (3) 1 of (chapter 254 of the Session Laws of 1901) *this act,* and who shall be a graduate of any legally chartered medical *or osteopathic* institution of the United States or any foreign country; or such permit may be so issued to any such applicant for license, complying with said conditions, who is shown to have been licensed by the board of registration and examination in any other state or territory of the United States or any foreign country whose standards of qualification for practice are equivalent to those of this state. Any such temporary permit so issued shall, when recorded in the office of the county clerk in the county in which he resides, authorize the person receiving the same to practice medicine or surgery in the same manner as a permanent license up to the commencement of the next regular meeting of the state board of physicians and surgeons registration and examination following the date of issue when such permit shall expire; *Provided,* That neither the said board nor the secretary thereof shall have power to issue more than one temporary permit to any one person, nor to extend any such permit beyond the time herein limited.

SEC. 9. The state board of physicians and surgeons registration and examination shall adopt rules and conduct examinations in such manner that no person shall be discriminated against by reason of his school of practice.

SEC. 10. Each person receiving a certificate from the board shall, when designating himself professionally append to his name the letters normally designating the professional degree held by him. He shall display permanently in his office or other place of business: (1) the certificate or certificates issued to him hereunder; and (2) the diploma, degree or other evidence of his graduation from the professional school or college to which reference has hereinabove been made.

SEC. 11. Sections 65-1001, 65-1002, 65-1003, 65-1005, 65-1006, 65-1008, 65-1201, 65-1202, 65-1203, 65-1204, 65-1205, 65-1206, 74-1001 and 74-1201 of the General Statutes of 1935 and sections 65-1207 and 65-1208 of the General Statutes Supplement of 1941 are hereby repealed.

SEC. 12. This act shall take effect and be in force from and after its publication in the official state paper.

Several hearings have been held on the bill before the House Committee on Hygiene and Public Health. Dr. Henry N. Tihen, President of the Society and Dr. J. L. Lattimore, President-Elect have appeared before the committee as have several members of the osteopathic group.

FLIGHT SURGEONS

Word has been received in the office that Lt. Spencer H. Boyd, formerly of Topeka; Lt. Letteer Lewis, formerly of McPherson; Lt. F. A. Thorpe, formerly of Pratt; Capt. R. E. Bennett, formerly of Beloit, have been transferred to various flight schools in California, Texas and Utah, where they will receive training as flight surgeons.

To explain the term flight surgeons we wish to quote a brief note from the Journal of the Indiana State Medical Society: "Much is being written these days concerning the flight surgeons, a group of young medical men chosen for special training in this field. Of late we have been looking into the matter and find that this training is quite some thing; takes a period of several monhs of intensive study, plus several trips hrough a man-made variance of atmospheric pressure, on through extremely lower temperatures, such as found in the stratosphere. On completion of the course the flight surgeon is assigned to an air squadron, going wherever the squadron is assigned. It appears popular with many of our younger men".

OSTEOPATHIC BROCHURE

Dr. Henry N. Tihen, President, advised the members of the Society on January 7 of the osteopathic situation in the letter a copy of which follows. Enclosed in the letter was a revised reprint of the brochure on "Facts of Ostopathy", the booklet which was originally published by the Society in 1938. Incorporated in the new brochure was the Military Honor Roll of the 464 Kansas physicians serving in the United States armed forces as of January 1, 1943.

"To the Members of The Kansas Medical Society":

"It seems advisable to make a report on the legislative situation to all of our members at this time. We are en-

closing a brochure on the FACTS OF OSTEOPATHY. It is hoped that each member will read this brochure through carefully and completely in order that each one may be able more clearly to present the position of the medical profession in an educational way where desirable. The legislative situation at present may be summarized as follows:

"1. The basic aim of our own activities is the upholding of high standards of medical and surgical care for the people of Kansas. We believe that our State not only is entitled to but desires the best in medical care. The Board of Medical Registration for many years has not licensed anyone to practice medicine in Kansas who is not a graduate of a Class A medical school. This standard should not be lowered. The medical profession of Kansas cannot compromise the medical welfare of the people of Kansas by any compromise on these standards.

"2. The basic aim of the osteopaths in the legislature, no matter in what form their bill is presented, is to secure laws giving them privileges in the practice of medicine and surgery. It is an incontrovertible fact that the osteopathic schools have not the slightest semblance of adequate standards for training their students in medicine or surgery and therefore the granting of any such privileges to the osteopaths in this State means the lowering of the standards of medical and surgical practice not only for the present but for generations to come. Let the fact be plain that the osteopaths are asking for privileges which they are not qualified by training to exercise and these privileges in unqualified hands are dangerous to the public welfare.

"3. The foremost achievement of the medical profession during the past fifty years has been its improvement of the competency of medical and surgical practice. The major portion of that progress has come about through enforcement of more stringent requirements for medical education; through abolishment of numerous inadequate medical schools and through insistence upon longer and more thorough training of medical students. Hence, after fifty years of diligent work in this direction, it is not desirable in the public interest to sweep away this progress and to commence again to issue medical and surgical licenses to persons who are not adequately trained—or not trained at all—in the practice of medicine and surgery.

"4. It is probable that the osteopaths will ask for these privileges on the basis of a shortage of physicians in Kansas under wartime conditions. It is true that we have a large number of doctors of medicine in the armed forces serving our country. However, the Procurement Committee in Kansas has done an excellent work in safe-guarding the medical care of the civil population and while often the doctor of choice of many of our people is in the service, adequate medical care is being maintained and will be maintained on the home front.

"5. We are proud of the number of our doctors in service caring for the sons of Kansas in all parts of the world. It seems very unlikely that the people of Kansas or the legislators will be so unappreciative of the service of our doctors in the armed forces as to pass any laws detrimental to medical standards when these medical men in service are unable to be present to defend these standards. We would like to call attention to the fact that the medical military services have not used osteopaths as medical officers because they know that they are not qualified for the practice of medicine.

"6. We likewise would like to call attention to the fact that as soon as the war is over a large number of highly trained medical men will be returned to our State to furnish every county and every community medical and surgical care of the highest quality. There is no need for the lowering of medical standards.

"7. During this war-time emergency when the efforts of everyone should be directed toward winning the war, the medical profession would like to devote all of its time and its energies to the winning of this war and we will not bring in any controversial legislative matters of our own until after the war is won. We hope we will not have to spend our time fighting controversial legislative problems brought in by the osteopaths.

"8. The medical profession recognizes the rights of osteopaths to practice osteopathy for which they are trained and licensed. We have no quarrel with them on the rights of practice in the field of osteopathy.

"The osteopaths have introduced a bill into the House of Representatives asking for a composite board. We will oppose this to the limit. Realizing that you are very busy caring for the sick people of Kansas, your officers will not call on your time during the meeting of the legislature unless quite necessary. If we do call, we will expect 100 per cent cooperation."

COLORADO LOSES EXECUTIVE SECRETARY

Word has been received that on February 1, Harvey T. Sethman, Executive Secretary of the Colorado State Medical Society and managing editor of the Rocky Mountain Medical Journal, was called to duty as Captain in the medical administrative corps of the United States Army.

Mr. Sethman had been with the organization for fourteen years and many of the Kansas members will remember meeting him at our 1940 state meeting held in Wichita. He was granted leave of absence from his position for the duration of his military service.

JOURNAL OFFICE

Over the Journal desk each month come many changes of address. These are interesting to note and possibly also of interest to members, and we believe that for the time at least some of these changes will be noted for your information.

Major W. C. Schwartz from Camp Wallace, Texas to Dallas, Texas.

Capt. Kenneth J. Gleason is now at Camp San Louis Obispo, Calif., and writes that he has not been receiving his Journal.

Major Maurice A. Walker has been assigned to Baxter General Hospital, Spokane, Washington.

Lt. Gregg B. Athy to Station Hospital, Foster Field, Texas.

Major Ralph L. Drake to Camp Hale, Colorado.

Capt. C. D. Kosar to Camp Hulen, Texas.

Capt. Lyle F. Schmaus to Station Hospital, Ft. Snelling, Minn.

Capt. W. G. Weston to Carmel, Calif.

Lt. John C. Mitchell to Station Hospital, Foster Field, Victoria, Texas.

My official address is Lt. James May, U. S. Naval Mobile Hospital No. 5, San Francisco, Calif. This is so I may receive the Journal regularly.

Lt. V. E. Brown to Fort Riley, Kansas.

Lt. Clarence G. Munns, La Salle Apt. No. 928, Washington, D. C.

Lt. Comdr. Lucius E. Eckles to the National Naval Medical Center, Bethesda, Maryland.

NARCOTIC PRESCRIPTIONS

The central office is in receipt of a very interesting letter from Mrs. Clara Miller, Executive Secretary of the Kansas Pharmaceutical Association which we believe is of great interest to our members:

"Here is an article I published in the last K.P.A. News—" and the article follows:

"ABOUT NARCOTICS: Doctors must write narcotics Rxs in ink, indelible pencil or typewriter, and sign in ink. Date, name, address of patient, and doctor's address and narcotic registry number must be on all narcotic Rx. In case of a refill, it is prohibited to write on the blank, Refill Rx No. A complete prescription must be written. Nor may narcotic Rx be prescribed via the telephone. The law specifies that Rx for narcotics must be received by the pharmacist before the medicine is delivered.

"On the druggist's or pharmacist's side, all such Rx written in pencil must be rejected, and those also which do not show the patient's name and address, the date, and the doctor's registry number. Druggists are forbidden to honor orders to "Refill Rx No."

Mrs. Miller says further "Every month we run articles of this type in an effort to keep our boys abiding by these narcotic laws. Always we have calls and letters from the druggists saying could the Medical Association work with us in urging the doctors not to write prescriptions in pencil and to cooperate in all ways to keep us from violating this law?"

"Inspectors are everywhere now and you know we are going to have some trouble about these narcotic prescriptions during this war period."

VICTORY BOOK CAMPAIGN

The 1943 sponsors of the Victory Book Campaign, the American Library Association, the American Red Cross and the United Service Organizations, have requested that we advise our members of the importance of the campaign, undertaken at the request of the armed forces. We wish to quote the following paragraph from their recent letter:

"We believe the readers of your publication are the kind who buy books—popular or technical—and that they will be delighted to contribute some for the enjoyment and education of our soldiers, sailors and marines. And we know that you will cooperate by telling them about the campaign in your pages."

Their advertising slogan is "Our men need books—Send all you can spare." It is their belief that good books should be passed along to men in service, by leaving them at the nearest collection agency, which may be your schools or your libraries.

WAR MEDICINE BECOMES A MONTHLY

War Medicine, which first appeared in January, 1941, published by the American Medical Association in cooperation with the Division of Medical Sciences of the National Research Council, became a monthly on January, 1943.

The articles in general deal with the war medical problems and to the present time the magazine has been published bi-monthly.

BLIND PROGRAM

Dr. William W. Reed, state supervising ophthalmologist for the Kansas State Board of Social Welfare, recently issued the following report pertaining to examination and treatment furnished under the Kansas blind program as of January 31, 1943:

AID TO THE BLIND

	Jan.	'38 to Date
New Applicants—		
Approved	7	2,691
Ineligible	10	2,007
Total	17	4,698
Re-Examinations—		
New Approvals	4	
Re-Certifications	5	
Ineligible	1	
Total	10	533
Total Examinations Given	27	5,231
Total New Approvals for "A.B."	11	

RESTORATION OF SIGHT

New Recommendations for Treatment Service—			
New Examinations	4		
Re-Examinations	2		
Total	6		1,225
Indigents Receiving Eye Care	112		
Completed Treatment Cases		Re-Op.	
Still Eligible for "A.B." after Treatments	9		272
Ineligible for "A.B." after Treatment	10	—1	453
Totals	19	—1	725

PREVENTION OF BLINDNESS

	Jan.		'38 to Date
New Recommendations for Treatment Service—			
New Examinations	5		666
Re-Examinations	0		
Total	5		666
Indigents Receiving Eye Care	68		
Completed Treatment Cases		Re-Op.	
Still Ineligible for "A.B."	20	1	459
Eligible for "A.B." (Decrease in Vision)	3		12
Totals	23	—1	471

WORKMEN'S COMPENSATION FEE SCHEDULE

Mr. Erskine Wyman, Commissioner of Workmen's Compensation of the State, recently published a pamphlet containing a new fee schedule for that department, effective as of May 1, 1942. The new schedule was compiled in collaboration with the Society Committee on Industrial Medicine.

The booklet contains in addition to the new schedule, a synopsis of the State law, together with suggestions on how to rate the various types of disabilities.

"MEDICAL FEES

Visits and Miscellaneous Services

Office, first visit, including report	$ 3.00
Office, subsequent visits	2.00
Office, dressings	2.00
Office, superficial lacerations, with report	3.00
Sutures, skin, routine fee, plus for each stuture	.75
First visit, day, place of injury home or hospital, including report	4.00
First visit, day, place of injury, home or hospital, including report	5.00
Subsequent visits, day, home (7 a.m. to 9 p.m.)	3.00
Subsequent visits, night, home (9 p.m. to 7 a.m.)	5.00
Subsequent visits, day, hospital (7 a.m. to 9 p.m.)	2.00
Subsequent visits, night, hospital (9 p.m. to 7 a.m.)	4.00
Examination, routine physical, including report	3.00
Examination, general physical and special, including detailed report	10.00
Physical therapy, including all modalities	2.00
Electrocardiogram	10.00
Spinal puncture	10.00
Blood transfusion direct or indirect (fee for doctor extra)	25.00
Gastric lavage (poison)	5.00
Skin patch test	2.00
Pericardial paracentesis	15.00
Abdominal paracentesis	10.00
Thoracic paracentesis	10.00
Neo-salvarsan—including drug	5.00
Injection (veno surgery)	3.00
Expert testimony	25.00

NOTE.—Burns and scalds, according to area involved; routine fee plus cost of extraordinary amount of dressing material, if the record of the case shows that it was necessary.

Tetanus antitoxin, routine fee plus cost of drug.

Consultation with specialist, same charge as routine fee.

Milage, each mile outside city limits more than two from office 50c one way.

ANAESTHESIA

Gas, minor	$ 5.00
Gas, major	10.00
Ether, minor	5.00
Ether, major	10.00
Spinal	10.00
Rectal (when performed by other than operator)	10.00
Intravenous, minor	5.00
Intravenous, major	10.00

NOTE.—Local anaesthesia by operator is part of operating fee.

AMPUTATIONS

Arm, disarticulation, or through head or neck	$100.00
Forearm, hand at wrist or carpus	75.00
Metacarpus	35.00
Finger or toe	25.00
Thigh, disarticulation at hip	150.00
Femur	100.00
Leg	75.00
Foot through metatarsus	50.00

In the case of the amputation of more than one finger or toe, a charge of fifty per cent of the original fee shall be made for each additional finger or toe amputated.

DISLOCATIONS

Temporomandibular	$ 10.00
Spine	100.00
Shoulder	35.00
Clavicle	30.00
Elbow	35.00
Thumb	10.00
Thumb, reduction open	50.00
Finger	10.00
Finger, each additional	5.00
Hip	50.00
Knee	50.00
Patella	10.00
Knee, meniscus	15.00
Ankle	25.00
Astragalus	35.00
OsCalcis	25.00
Metacarpal	10.00
Metatarsal	10.00
Tarsal	25.00
Carpal	20.00
Toe, reduction and splint	5.00
Wrist	20.00

NOTE.—Shoulder, recurrent—operation by arrangement.

After-Care. The above fees for Dislocations include the usual period of after-care, exclusive of x-rays, hospital, and anaesthetic service.

Multiple Dislocations. In the case of more than one dislocation the fee shall be the one prescribed for the major dislocation, plus an additional fifty per cent of the fee prescribed for the minor dislocations, but limited to two times the greater fee. Superficial injuries not requiring extensive attention are not to carry cumulative charges.

FRACTURES

Skull, nonoperative	$25.00 to $100.00
Skull, operative, not within dura	100.00
Skull operative, within dura	150.00
Maxilla, nonoperative	15.00
Maxilla, operative	50.00
Mandible, unilateral, with wiring	75.00
Mandible, bilateral, with wiring	100.00
Malar	40.00
Nose	25.00
Clavicle	35.00
Scapula	35.00
Ribs, one	15.00
Ribs, four or more, complicated	40.00
Sternum	20.00
Sternum, complicated	75.00
Vertebra	100.00
Vertebra processes, nonoperative	10.00
Humerus	75.00
Radius or ulna	50.00
Radius and ulna	75.00
Radius into elbow joint	50.00
Colles	50.00
Elbow (including humerus, radius and ulna)	75.00
Carpal	35.00
Metacarpal	20.00
Finger	15.00
Femur	125.00
Patella	50.00
Tibia	50.00
Tibia into knee joint	75.00
Fibula	35.00
Tibia and fibula	75.00
Potts fracture	75.00
Metatarsal	20.00
Toe	15.00
Sacrum	50.00
Pelvis	75.00
Pelvis, multiple	100.00

OsCalcis	75.00
Astragalus	50.00
Tarsal	25.00

NOTE.—Fractures requiring open reduction, add fifty per cent of flat fee. Semiopen (pins and cast) charge twenty-five per cent of flat fee.

Multiple injuries treated by one physician, requiring extensive surgical dressings or care, are to be charged for the greatest plus one-half of the lesser fees but limited to two times the greatest fee. Superficial injuries not requiring extensive attention are not to carry cumulative charges. This rule does not apply to multiple x-ray or pathological examination.

Multiple Fractures.—Add to the greater fee a sum equal to fifty per cent of each lesser, not exceeding two times the greater.

After-Care. The above fees for fractures include the usual period of after-care, exclusive of x-rays, hospital, and anesthetic service.

Proration of Scheduled Unit Fee.—When the schedule specifies a unit fee for a definite treatment and period of after-care, and the patient is transferred from one to another physician, the employer (or carrier) is responsible for the amount stated in the schedule. If the concerned physicians agree upon amount of proration they shall render separate bills accordingly; in the event of no agreement or disagreement, the matter shall be settled by the Board of the local County Medical Society of the first attending physician, or by an arbitration committee appointed by it—without cost to the contestants.

If in the course of treatment consultation is necessary, authorization should be obtained except in emergency.

SURGICAL PROCEDURES

Incision for superficial abscess as furuncle or boil	$ 3.00
Deep abscess or infection	25.00
Excision of kidney	100.00
Fixation of kidney	100.00
Cystotomy	50.00
External urethrotomy	50.00
Hydrocele—radical	50.00
Hydrocele—tapping	10.00
Orchidectomy	50.00
Epididymectomy	50.00
Laparotomy, exploratory	100.00
Encephalogram—by arrangement.	
Osteomyelitis—by arrangement.	
Removal of nail, finger or toe, including local anesthetic	3.00
Excision of sub-deltoid bursa	50.00
Excision of prepatellar bursa	35.00
Ganglion by excision	35.00
Repair tendon, one primary	25.00
Tendon, each addition (not to exceed $100)	10.00
Tendon, secondary—by arrangement.	
Nerve suture, primary	25.00
Nerve suture, secondary—by arrangement.	
Hernia, by injection—by arrangement.	
Hernia, single	75.00
Hernia, double	100.00
Hernia, post surgical	75.00
Hernia, ventral	75.00
Bone graft—for nonunion of femur	150.00
Bone graft—for nonunion of tibia	150.00
Bone graft—humerus	150.00
Bone graft—forearm—one bone	125.00
Bone graft—forearm—two bones	150.00
Foreign bodies-extraction, subsutaneous, without anesthetic	3.00
Foreign bodies—extraction, subcutaneous, with local,	10.00
Foreign bodies—extraction, deep, general anesthetic	25.00
Astragalectomy	75.00
Subastragalar arthrodesis	100.00
Retropulsed intervertebral disc	150..00
Coccyx, removal	50.00
Spinal fusion	200.00
Removal of meniscus from knee	100.00
Rib excision or resection	50.00
Arthrodesis of hip	150.00
Arthrodesis of wrist	75.00
Arthrodesis of knee	100.00
Arthrodesis of shoulder	100.00

NOTE.—Above extractions do not include removal of foreign body from eye or orbit.

CONSULTATIONS AND CONSULTANT CARE

All special examinations, with reports	$10.00
Subsequent check-up with reports	3.00

FEE SCHEDULE OF PHYSICIANS SPECIALIZING IN DISEASES OF THE EYE, NOSE AND THROAT

EYE

Foreign body of cornea and sclera:	
(a) Attached to cornea or sclera but not imbedded, with report	3.00
(b) Simple imbedded, with report	3.00
(c) Difficult or complicated—including cases requiring use of magnet	10.00
Cauterization of corneal ulcer	5.00
Treatment extensive burn of the cornea (initial treatment)	5.00
Plastic operation on lids—by arrangement.	
Simple, office, eye check-up (observation, no refraction, no retina study), with report	3.00
Complete office examination, with refraction and report	10.00
Complete ophthalmological examination and report for court purposes (on order of Commissioner)	25.00
Refraction alone and prescription for glasses	5.00
Subsequent office visit	2.00
House visit, routine, for examination and opinion with report	3.00
Hospital visits	2.00
Removal intra-ocular foreign body	75.00
Removal of intra-orbital foreign body	75.00
Primary suture lid and conjunctival wounds	10.00
Penetrating wounds of eyeball:	
(a) Scleral	25.00
(b) Corneal, requiring iridectomy	50.00
Iridectomy	50.00
Cataract extraction (regardless of type—includes after care)	100.00
Discission of Capsule	50.00
Detachment of retina	75.00
Enucleation of eyeball	50.00
Evisceration of eyeball	50.00
Traumatic glaucoma operation	75.00
Traumatic symblepharon	50.00
Submucuous resection of nasal septum	60.00
Direct laryngoscopy	25.00
Bronchoscopy	40.00

X-rays

Hand, including fingers	$ 5.00
Wrist	5.00
Forearm	5.00
Elbow	5.00
Humerus	5.00

Foot	7.50
Ankle	7.50
Leg	7.50
Knee	7.50
Femur	7.50
Shoulder	7.50
Clavicle	7.50
Scapula	7.50
Hip	10.00
Head and face	10.00
Nasal bones	10.00
Mandible	5.00
Cervical spine	10.00
Thoracic spine	10.00
Lumbar spine	10.00
Pelvis	10.00

Any two spinal regions, discount total twenty per cent.
Any three spinal regions, discount total twenty per cent.

Thoracic cage	10.00
Lungs and head	10.00
Abdomen and gastro-intestinal	10.00
Abdomen and gastro-intestinal with opaque medium	15.00
Genito-urinary-retrograde pylography with injection	15.00
Teeth, one	1.50
Teeth, complete	10.00
Foreign body-eye-location	10.00
Fluoroscopy	3.00
Fluoroscopy for foreign body	3.00
Consultation	5.00

X-ray fees are based upon the following:

(1) An adequate examination regardless of the number and size of films necessary for such examination..

(2) A written report giving reasonably accurate description of findings obtained.

(3) An interpretation also in writing of clinical significance of the x-ray findings, and, if required, a consultation with the attending physician or surgeon.

NOTE.—Foreign body, same as part involved.

Bedside—institutional—add fifteen per cent to normal fee for part.

Examination, opposite side for comparison—discount fifty per cent total.

Re-examination, to determine progress—discount thirty-three and one-third per cent.

NURSES' AIDES FOR VETERANS' HOSPITALS

The Washington, D. C., Defense Office has mailed the following information: "Training of larger numbers of nurses' aides and additional hours of service for those already trained will be necessary as a result of a request from Brig. Gen. Frank T. Hines, Administrator of Veterans' Affairs, for the assignment by the American Red Cross of nurses' aides to Veterans Administration Facilities. The Medical Division of the Office of Civilian Defense issued a memorandum October 31 to its Regional Medical Officers announcing the new arrangement.

"The Red Cross in a memorandum addressed to its Area Offices for transmission to local chapters approved this assignment for nurses' aides, but emphasized that the needs of the civilian hospitals and other community organizations should not be neglected. In communities without facilities for training nurses' aides, an effort should be made to recruit them from cities nearby, the memorandum said. Requests should be sent to the Area Offices of the Red Cross.

"Nurses' aides who serve in Veterans Administrative Facilities will be paid at the rate of one dollar a year, since the Veterans' Administration may not under the law accept nursing service without payment for it. These aides will then be considered government employees and must be American citizens. The Veterans' Administration is prepared to furnish quarters, meals and laundry when necessary. Assignment of aides to the hospitals will be the responsibility of the local Red Cross nurses' aide committee, of which the local chief of Emergency Medical Service is a member.

"NEW METHOD OF ADMINISTERING MORPHINE —Because of the critical shortage of tin, the United States Office of Civilian Defense has been unable to procure syrettes for administration of morphine by physicians of Emergency Medical Service. To meet this serious difficulty, a new device using glass and plastic has been developed.

"This device consists of a small, sealed-glass ampule containing ¼ gr. or ½ gr. of morphine in solution. This solution is under sufficient pressure to eject the entire contents. A piece of transparent plastic tubing encloses the neck of the ampule and connects it to the hub of the needle. The shaft of the needle is enclosed in a small glass tube, to which is attached a stylet. At the hub of the needle within the plastic tube is a small filter.

Following is the method of using the ampule:

"1. The body of the ampule is grasped in the right hand.

"2. The glass tube protecting the needle is withdrawn by a twisting and pulling movement of the fingers of the left hand.

"3. With the needle pointing down and the body of the ampule vertical to the skin, the needle is inserted by jabbing it under the skin.

"4. When the needle is in place, and with the ampule vertical to the skin, pressure is exerted with the thumb and two fingers on the plastic tubing to break the neck of the ampule. It is important that the ampule be held vertical to the skin, in order that morphine may not be lost by improper technic.

"5. The pressure within the ampule ejects the contents. The filter prevents glass splinters from clogging the needle.

"6. When the ampule is empty, the needle is withdrawn and the whole device is discarded."

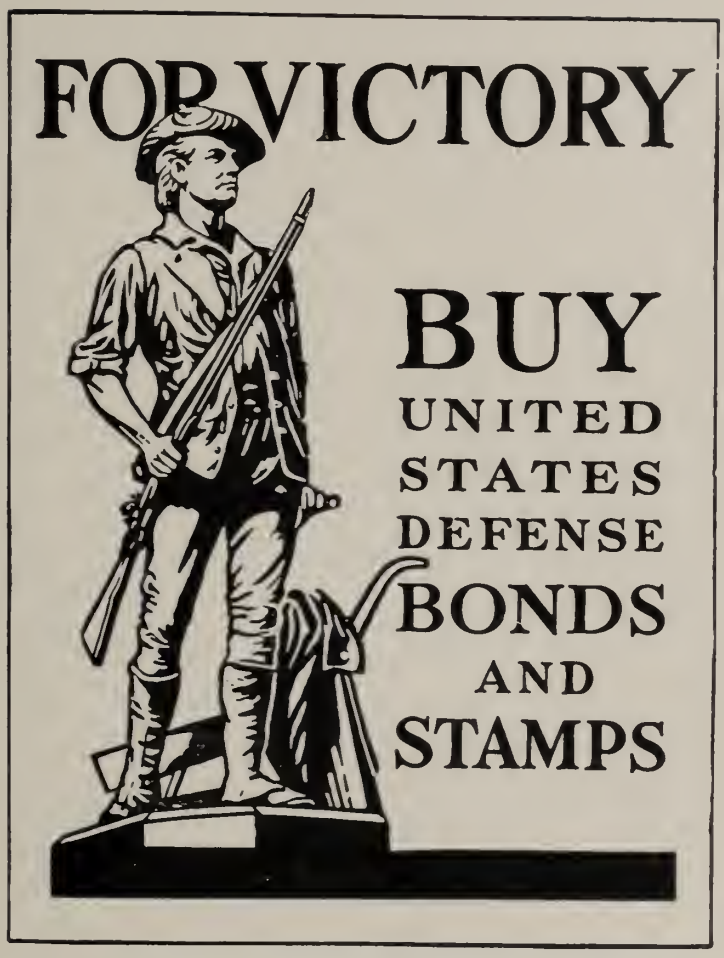
PLASMA FOR CIVILIAN DEFENSE

The Office of Civilian Defense of Washington, D. C. recently released the following information in regard to plasma for civilian defense:

"The Medical Division of the Office of Civilian Defense and the United States Public Health Service report the current status of the blood plasma program which was initiated in the early spring.

"The report indicates that 130 hospitals have now received grants-in-aid and are preparing reserves of plasma to total at least 63,130 units. In addition to this reserve, 27,500 units of frozen plasma have been obtained through the Army and Navy from blood collected by the American Red Cross. This supply has been distributed. The medical Division has also procured 37,500 units of dried plasma from blood collected by the American Red Cross, and this supply is in process of distribution.

"The total reserve, which is largely concentrated in the 300 mile coastal target areas, will be 126,630 units for treatment of casualties resulting from enemy action. In addition, 1250 units are in Puerto Rico and 250 in Alaska.



WAR NEEDS MONEY!

It will cost money to defeat our enemy aggressors. Your Government calls on you to help now.

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Bonds cost $18.75 and up. Stamps are 10¢, 25¢ and up.

The help of every individual is needed.

Do your part by buying your share

"In addition to these sources of plasma, the Red Cross is distributing to target areas 5,000 units which will be available to the Office of Civilian Defense for treatment of civilian casualties resulting from enemy action. Many hospitals which have not received grants under the OCD-USPHS program are also preparing plasma reserves which total approximately 50,000 units.

"Plasma required for the treatment of war-related injuries may be obtained by any community through its Chief of Emergency Medical Service. To meet such emergencies, plasma may be transferred: (1) within a State by the State Chief of Emergency Medical Service; (2) within a Region by the Regional Medical Officer; and (3) from one Region to another by the Medical Division, United States Office of Civilian Defense."

GAS SPECIALISTS

The Washington office of Civilian Defense recently issued information in regard to courses for Gas Specialists:

"A new five-day specialist course for persons responsible for the organization of gas defense in the target areas will be presented in the six War Department Civilian Protection Schools conducted on behalf of and in collaboration with the United States Office of Civilian Defense.

"This is the first course to be presented in cooperation with the Chemical Warfare Service for State Gas Consultants and Senior Gas Officers, who are responsible for the organization of community gas defense. Courses have been presented at regional schools for medical school representatives who have in turn been responsible for the education of practicing physicians in the medical aspects of chemical warfare. These schools have been conducted in the East, and plans are under way for the presentation of such schools elsewhere in the United States.

"The first session of the gas specialists' course will be at Amherst College, Amherst, Massachusetts, November 29 through December 4. The course will be offered December 13-18, inclusive, at the other War Department Civilian Protection Schools at Loyola University, New Orleans, Louisiana; Purdue University, Lafayette, Indiana; University of Washington, Seattle; Stanford University, Palo Alto, California; and Occidental College, Los Angeles.

"Presentation of the specialized course dealing with gas defense is part of a new plan of instruction in the War Department Civilian Protection Schools. The ten-day general course formerly given by the schools was dis-continued with the session of November 1-11, and the new plan of specialized courses to be given in five days will be instituted with the sessions announced in the foregoing paragraph. The other courses cover plant protection, basic civilian protection and instruction for staff members.

"The gas specialists' course will at first be limited to State Gas Consultants and Senior Gas Officers and their assistants, the announcement said. Emphasis will be placed on the administrative organization of State and local gas defense programs and the training of civilian protection personnel, and the interrelated activities of all units of the United States Citizens Defense Corps at the time of a gas attack will be considered in detail. It is an advanced course open to those with college degrees in chemical, sanitary or civil engineering, in chemistry or equivalent scientific training.

"Inasmuch as the Medical Division of the Office of Civilian Defense is responsible through its gas protection section for the administrative and technical organization of the gas program, responsibility for recruitment of students for the gas specialists' course was delegated to the Regional Medical Officers and the Regional Sanitary Engineers."

FECALITHS AND GALLSTONES AS CAUSE OF INTESTINAL OBSTRUCTION

(Continued from Page 41)

On August 4, 1940, about midnight she had another attack, attended with severe pain in the stomach. The patient was nauseated all the time and vomited quite frequently. No relief from enemas. No cathartics had been taken. This continued until late in the evening of August 5, when I was again called and she consented to go to the hospital. A Levin tube was inserted which gave her some relief. Repeated enemas were used, with negative results. No relief having been obtained, an operation was advised, and accepted.

Operation August 7, 1940, about 10:00 p.m. The small intestine was very much congested and distended, from slightly above the cecum. Below the gut was flat, and a large, hard mass was felt just below the distended gut. This was within eight or ten inches of the cecum. Stone was removed through longitudinal incision in the intestine. Intestinal wound closed, abdominal wound closed, with drainage. Levin tube was reinserted. Enemas were repeated. The patient had a somewhat stormy time for a few days. A fecal fistula developed, which, in the course of a few weeks, closed. Otherwise, she made an uneventful recovery. There is at this time a fairly good sized ventral hernia at the seat of the original abdominal incision. Otherwise, the patient suffered no after effects and is now in good health.

MEMBERS

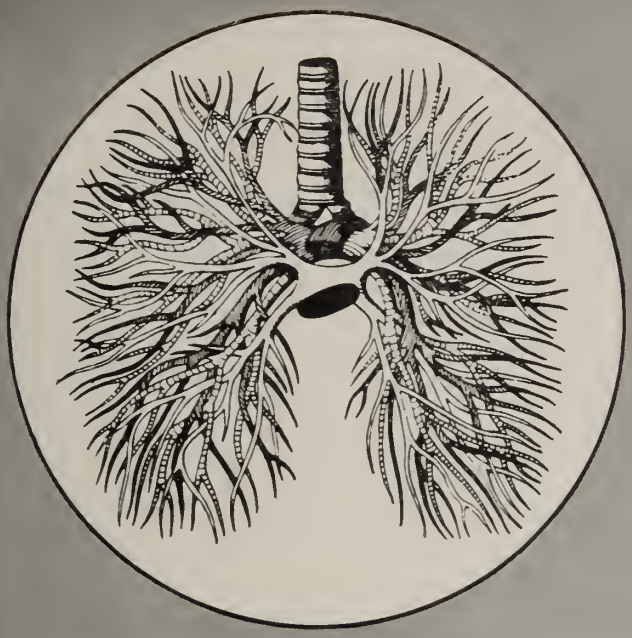
Dr. David T. Loy, formerly of Great Bend, has moved to Kansas City where he will be associated with Dr. J. A. Billingsley.

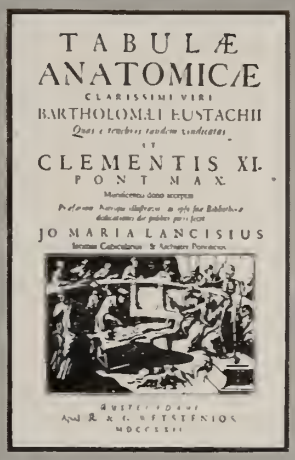
Dr. William C. Menninger, formerly of Topeka and now a Lt. Col. in the United States Army located in Atlanta, Georgia, is the author of an article entitled "Arterial Hypertension Following Metrazol Shock Therapy" which was published in the January, 1943 issue of the Archives of Neurology and Psychiatry.

Dr. C. F. Taylor of Norton has been chosen as Secretary-Treasurer of the Northwest Kansas Medical Society to fill the unexpired term of Dr. Wm. F. Stone who is serving in the armed forces.

Dr. G. W. Bale of Clay Center was appointed as coroner of Clay County to succeed Dr. G. B. McIlvain who has recently entered the armed forces.

The article by Dr. Clarence W. Erickson of Pittsburg on "Diagnosis and Treatment of Early Congestive Heart Failure" which was published in the October 1941 issue of the





● From the rare volume, "Tabulae Anatomicae" by Bartholomaei Eustachii, comes this interesting illustration of the bronchi, arteries and veins of the lungs. Published in 1722.

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Adrenalin* saunds a clear, unwavering nate in its marked ability to dilate and clear the branchiales in branchial asthma . . . Adrenalin in aqueaus salutians for speedy relief in asthmatic emergencies . . . Adrenalin in Oil far sustained all-night relaxatian and camfart. Na medicatian is mare effective, none more widely relied upon.

Adrenalin, an epinephrine manufactured exclusively by Parke, Davis & Campany, is af value in preventing and treating variaus allergic states, in checking superficial hemarrhage, far stimulating vital centers in certain crises.

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Journal was abstracted and translated and appeared in the September 1942 issue of Revista Medica Municipal, published in Rio de Janeiro, Brazil.

COUNTY SOCIETIES

At a recent meeting of the Bourbon County Medical Society, which was held in Fort Scott, the following new officers were elected: Dr. J. R. Prichard of Fort Scott as President, Dr. Herbert Randles of Fort Scott as Vice-President and Dr. J. D. Hunter of Fort Scott as Secretary-Treasurer.

The Butler-Greenwood County Medical Society held a dinner meeting at the Allen County Memorial Hospital in Augusta on January 8. The scientific program was presented by members. New officers elected at the December meeting were: Dr. S. N. Mallison of Augusta as President and Dr. W. E. Janes of Eureka as Secretary-Treasurer.

The first meeting of the Clay County Medical Society was held at the Municipal Hospital in Clay Center on January 13. Dr. T. C. Kimble of Miltonvale was elected the President of the organization for 1943, Dr. A. W. Butcher of Wakefield was elected as Vice-President, Dr. F. C. Shepard of Clay Center was elected as Secretary-Treasurer. Dr. F. R. Crosen of Clay Center, Dr. G. W. Bale of Clay Center and Dr. Warren Morton of Green were elected to the Board of Censors. February 10 is the next meeting date of the society.

The Cowley County Medical Society were hosts to the medical officers of Strother Field at the annual banquet of the society, which was held on January 21 at Arkansas City. The new officers of the society are as follows: Dr. Ione Clayton of Arkansas City as President, Dr. M. J. Dunbar of Winfield as Vice-President, Dr. J. L. Wentworth of Arkansas City as Secretary-Treasurer.

The Crawford County Medical Society held a business meeting in Pittsburg on January 7 at which the following officers were elected: Dr. C. H. Benage of Pittsburg was re-elected as President, Dr. E. C. McDonald of Pittsburg as Vice-President, Dr. G. L. Millington of Girard as Secretary Treasurer.

At a special meeting of the Franklin County Medical Society held in Ottawa on January 24 the following new officers were elected: Dr. Robert A. Gollier of Ottawa as President, Dr. Homer E. Markham of Ottawa as Vice-President and Dr. P. R. Young of Ottawa as Secretary-Treasurer.

The Leavenworth County Medical Society elected the following officers at a recent meeting: Dr. A. J. Smith of Leavenworth as President, Dr. D. R. Sterett of Leavenworth as Vice-President and Dr. C. A. Bennett of Leavenworth as Secretary-Treasurer.

The Marion County Medical Society held a meeting at Marion on December 23 at which the following new officers were elected: Dr. A. K. Ratzlaff of Goessel as President, Dr. H. F. Janzen of Hillsboro as Vice-President, and Dr. R. R. Melton of Marion as Secretary-Treasurer. Dr. G. J. Goodsheller of Marion, Dr. W. M. Tate of Peabody and Dr. R. C. Smith of Marion were elected as Censors.

NEW WORK FOR AO ZYLONITE

On Duty with Wartime Civilians



Mr. and Mrs. Cilivian have buckled down to new duties. Serving with the American Women's Voluntary Services, Red Cross, Civilian Defense, and other wartime organizations. They are doing important work.

Along with Mr. and Mrs. Cilivian's new duties have come new problems. One of these is to equip themselves with eyewear that will meet the demands of their new and more strenuous activities.

AO Zylonite frames provide an eminently satisfactory solution. Precision-made from fine quality, well seasoned stock, AO Zylonite frames combine the needed sturdiness with comfort and good looks.

The diversified requirements of wartime duties emphasizes the advantages of AO Zylonite spectaclewear.

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NEW OPPORTUNITIES TO



Build Kansas INDUSTRY For War Production

and a Balanced Post-War Economy

Charles F. Kettering, during his recent visit to Kansas, made the statement that Kansans might soon be crossing corn stalks with gas wells.

He was alluding to the enormous potentials which he saw in Kansas through the industrial utilization of the state's vast resources, potentials in which Kansas crops are combined with Kansas minerals using Kansas manpower. Yet his voice was merely adding weight to the claims of Kansas technical men who have been studying these problems for many years.

It has remained for the events of 1942 to bear out these contentions. The demand for what was new to use in war production brought out plastics, with its kindred synthetic rubber problem. It brought about the need for dehydration of foods to save critically scarce shipping space. And other technical advances were put into production lines as the normal pace of progress gained years in the space of months.

Today there is opportunity to develop great new industrial utilizations of Kansas agricultural and mineral resources that fit into the war production program—and that provide a firm foundation upon which to build for desirable peacetime industrial balance. This balance must be obtained in order to offer jobs to the 80,000 to 100,000 men returning from the armed services, to provide a continuing source of employment for workers now in the state. and to assure Kansas youngsters of opportunity at home.

KANSAS
INDUSTRIAL DEVELOPMENT COMMISSION

The Mitchell County Medical Society met on January 19 at Beloit. The following were elected to office: Dr. H. B. Vallette of Beloit as President, Dr. R. E. Bennett as Vice-President, Dr. Hugh A. Hope of Hunter as Secretary-Treasurer. Dr. W. W. Weltmer of Beloit was elected as Censor and Dr. Hope as Delegate. Dr. Weltmer gave a paper on "Sulfa Drugs". Dr. Bennett, who was home on furlough attended the meeting.

The Pawnee County Medical Society held a business meeting in Larned on January 5. The following were elected to office: Dr. T. R. Frazer of Larned as President and Dr. J. A. Blount of Larned as Secretary-Treasurer.

The Sedgwick County Society held a meeting in Wichita on February 2. The scientific program included a motion picture on "Peptic Ulcer" from the Lahey Clinic in Boston, and a talk on "Treatment of Different Types of the Pneumonias" by Dr. C. F. Kemper of Denver, Colorado, Associate Professor of Medicine of the University of Colorado School of Medicine.

The Sumner County Medical Society held a business meeting on December 17 in Wellington, at which the following officers were elected: Dr. W. H. Neel of Wellington as President, Dr. R. C. McIlhenny of Conway Springs as Vice-President, Dr. J. A. Phillipsen of Wellington as Secretary-Treasurer and Dr. Neel as Delegate.

The Washington County Medical Society held a dinner meeting in Washington on January 11. A business meeting followed the dinner and the following members were elected to office: Dr. R. C. Gomel of Washington was elected as President, Dr. D. A. Bitzer of Washington as Vice-President, Dr. L. J. L'Ecuyer of Greenleaf was re-elected as Secretary-Treasurer.

The Wyandotte County Medical Society entertained with its annual President's inaugural dinner at the Hotel Muehlebach in Kansas City on January 30. The new officers for the year were installed.

DEATH NOTICES

Dr. Herbert G. Cabbell, 55 years of age, died on January 13 at his home in Lawrence. Dr. Gabbell was graduated from the Jenner Medical College of Chicago in 1912. He was a member of the Douglas County Medical Society.

Dr. Solomon Thos. Shelly, 87 years of age died at his home in Mulvane on January 17, following a long illness. He was born in Memphis, Missouri and was graduated from the Missouri Medical College of St. Louis, Missouri in 1883. He practiced for a time in Burrton and moved to Mulvane in 1880. He was a member of the Sumner County Medical Society, of which he was made an honorary member in 1936.

Dr. Geo. O. Speirs of Spearville, 67 years of age died on January 28 of a heart attack. He was born on June 20, 1875 in Hedrick, Iowa and graduated from the Rush Medical College of Chicago in 1900. He practiced first at Marion,

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SURGERY—Two Weeks Intensive Course in Surgical Technique starting February 8 and 22, March 8 and 22, and every two weeks throughout the year.
MEDICINE—One Month Course in Electrocardiography and Heart Disease starting the first of every month, except August.
FRACTURES AND TRAUMATIC SURGERY — Formal and Informal Courses.
GYNECOLOGY—Two Weeks Intensive Course starting April 5; Clinical and Diagnostic Courses.
OBSTETRICS — Two Weeks Intensive Course starting April 19; Informal Course.
OPHTHALMOLOGY—Two Weeks Intensive Course starting April 5.
OTOLARYNGOLOGY — Two Weeks Intensive Course starting April 19.
ROENTGENOLOGY — Courses in X-ray Interpretation, Fluoroscopy, Deep X-ray Therapy every week.
UROLOGY—Two Weeks Course and One Month Course available every two weeks.
CYSTOSCOPY — Ten Day Practical Course every two weeks.

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moving to Ellinwood in 1902 and in 1916 to Spearville. He was a member of the Ford County Medical Society and Councilor of The Kansas Medical Society for the Twelfth District.

Dr. Walter H. Weidling, 55 years of age, died on January 16 at his home in Topeka. He was graduated from the Rush Medical College of Chicago in 1913, and was a member of the Shawnee County Medical Society.

Dr. Enoch C. Wickersham of Independence, 86 years of age, died on September 18, 1942. He was graduated from the College of Physicians and Surgeons of Kansas City in 1901 and was an honorary member of the Montgomery County Medical Society.

Regards to the Axis—We've just returned from an inspection of war factories in California, or maybe it was Connecticut or Pennsylvania or Illinois; or, for that matter, any other of the forty-eight states or the Canadian provinces. This plant used to make knitting needles or watches or children's tin jumping jacks. Now it's making machine guns or anti-aircraft shells or tank treads or bomber motors. We're sorry we can't be too specific, but actually it doesn't matter—the story of intense productivity is everywhere we've been throughout the nation. When you see it, you realize how we're racing.

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We ate in the workers' cafeterias. There's generally a half hour for lunch. Prices are moderate to low, the food good, and the quantity man-sized. We had a huge lobster salad in one place for thirty cents. Living conditions are much worse, however. There's not nearly enough room for everybody. Bathing facilities are very limited. In some places, sleeping accommodations come in eight-hour shifts with three men using the same bed in rotation.

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WHEN DOCTORS ARE RATIONED—Dwight Anderson, Director of Public Relations of the Medical Society of the State of New York and Margaret Baylous, Therapist of Charleston General Hospital of Charleston, West Virginia. Published by Coward-McCann, Inc., 2 West 45th Street, New York City, priced at $2.00.

WAR GASES—Morris B. Jacobs, Ph.D., Food, Drug and Insecticide Administration, United States Department of Agriculture, 1927, Chemical Department of Health, City of New York, 1928, Formerly Lieutenant of the United States Chemical Warfare Service Reserves. Published by the Interscience Publishers, Inc., New York. This little book of 180 pages is priced at $3.00.

A VENTURE IN PUBLIC HEALTH INTEGRATION —The 1941 Health Education Conference of the New York Academy of Medicine. Published by the Columbia University Press, New York, 1942. The little booklet of fifty-six pages is priced at $1.00.

ADVANCES IN PEDIATRICS—Edited by Adolph G. DeSanctis, M.D., New York Post Graduate Medical School and Hospital of Columbia University of New York, Associate Editors: L. Emmett Holt, of Johns Hopkins Hospital of Baltimore, Maryland; the late A. Graeme Mitchell, M.D., of the Childrens Hospital of Cincinnati, Ohio; Robert A. Strong, M.D., of Tulane University of New Orleans, Louisiana; and Frederick F. Tisdall, M.D., of the Hospital for Sick Children of Toronto, Ontario, Canada. Published by the Interscience Publishers, Inc. of New York, New York. Priced at $4.50.

FRACTURES—Paul B. Magnuson, M.D., F.A.C.S., Associate Professor of Surgery of Northwestern University Medical School, Attending Surgeon of Passavant Memorial Hospital and Wesley Memorial Hospital of Chicago, Illinois. This Fourth Edition Revised and published by the J. B. Lippincott Company of Philadelphia, Pennsylvania, is priced at $5.50. The volume contains 511 pages and 317 illustrations.

AUTONOMIC REGULATIONS, Their Significance for Physiology, Psychology and Neuropsychiatry—Ernest Gellhorn, M.D., Ph.D., Professor of Physiology of the College of Medicine of the University of Illinois. Published by the Interscience Publishers, Inc., New York, N. Y., 1943. The book contains eighty illustrations, 373 pages and is prices at $5.50.

FUNDAMENTALS OF PSYCHIATRY — Edward A. Strecker, M.D., Sc.D., F.A.C.P., Professor of Psychiatry and Chairman of the Department of the Undergraduate School of Medicine of the University of Pennsylvania; Psychiatrist to the Pennsylvania Hospital and Attending Psychiatrist of the Psychopathic Division of the Philadelphia General Hospital. Published by the J. B. Lippincott Company of Philadelphia, the volume of 201 pages is priced at $3.00.

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THE 1942 YEAR BOOK OF PEDIATRICS—Edited by Isaac A. Abt, D.Sc., M.D., Professor of Pediatrics of the Northwestern University Medical School; Attending Physician, Passavant Hospital; Consulting Physician of the Children's Memorial Hospital and St. Luke's Hospital of Chicago, Illinois. With the collaboration of Arthur F. Abt, B.S., M.D., Associate Professor of Pediatrics, of Northwestern University Medical School; Associate Attending Pediatrician of Michael Reese Hospital; Attending Pediatrician of the Chicago Maternity Center; Attending Physician of the Spaulding School for Crippled Children and La Rabida Jackson Park Sanitorium of Chicago, Illinois. Published by the Year Book Publishers, of Chicago, Illinois, the book contains 512 pages and is priced at $3.00.

ANNUAL REPRINT OF THE REPORT OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION, For 1941. Published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois, 1942.

NEW AND NONOFFICIAL REMEDIES, 1942—Contains descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January, 1942. Published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois, and issued under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association.

THE 1942 YEAR BOOK OF GENERAL SURGERY—Edited by Evarts A. Graham, A.B., M.D., Professor of Surgery of Washington University School of Medicine and Surgeon-in-chief of the Barnes Hospital and of the Children's Hospital of St. Louis, Missouri. Published by the Year Book Publishers of Chicago, Illinois, the book contains 848 pages and is priced at $3.00.

THE 1942 YEAR BOOK OF INDUSTRIAL AND ORTHOPEDIC SURGERY—Edited by Charles F. Painter, M.D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital of Boston, Massachusetts. Published by the Year Book Publishers, Inc., of Chicago, Illinois, and priced at $3.00.

FUNDAMENTALS OF IMMUNOLOGY—William C. Boyd, Ph.D., Associate Professor of Biochemistry of Boston University School of Medicine; Associate Member of the Evans Memorial and Massachusetts Memorial Hospital of Boston, Massachusetts. Published by the Interscience Publishers, 215 Fourth Ave., New York, N. Y. The book of 446 pages is priced at $5.50 and its publication date was January 7, 1943.

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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Your Kansas Medical Assistants' annual dues are due. If you have not paid your dues at the present time, please send them to: Irene Miller, Treasurer, the Gazette Building, Emporia, Kansas. It is not necessary that you have a local organization to belong to the state organization. With your application for membership should be enclosed a letter from your physician stating that you have been employed as an assistant for one year or longer and this should be mailed with your remittance of fifty cents for state dues. The treasurer will return your membership card to you.

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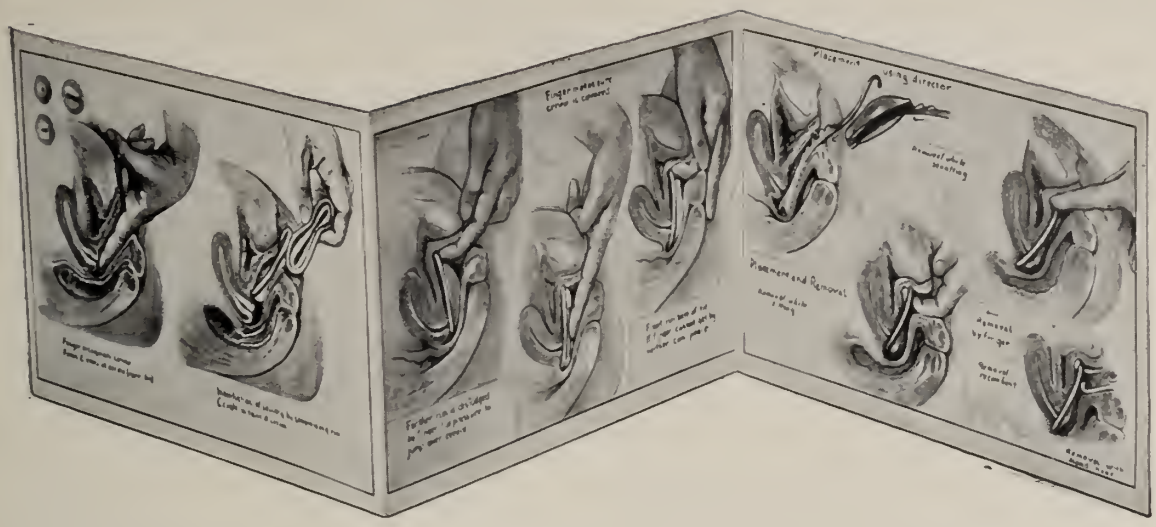
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AUXILIARY

PRESIDENT'S MESSAGE

When I read the list of Kansas doctors who are serving their country with the armed forces I cannot help but feel proud that Kansas is doing more than its share in this regard. I also am proud of their wives who make sacrifices in thousands of countless ways while their husbands are in service. But while we are remembering these men and their families, let us not forget the doctors who are fighting their battles on the home front. Their job is no less important.

Auxiliary work is getting into the home stretch with only three months to go before we make our final reports. I am planning on visiting nearly all the county units during the month of March, at which time I will give you informal reports of what we have accomplished to date. Our activities have necessarily been curtailed and while our membership has decreased somewhat, what we have lost in quantity we have gained in quality—not quality of membership, of course, but quality of interest.

Until I see you next month—au revoir.

Mrs. C. Omer West.

NATIONAL AUXILIARY MEMBERSHIP

The December 1942 issue of the Bulletin of the Woman's Auxiliary to the American Medical Association published a comparative study of the membership of each state organization since 1922. The date was furnished by Mrs. T. Mitchell Burns of Denver, Colorado, who is first Vice-President of the national organization.

Kansas was not listed as having a membership in 1922 but in 1927 was reported with a membership of ninety-five which was exceeded by only six other states. In 1942 the Kansas membership was 456 with fourteen county auxiliaries in the state.

The summary covers forty-one states and the District of Columbia and is an interesting one. In 1922 there were 345 national members and 345 county groups. In 1942 there were 27,532 members with 657 county organizations in the various states.

AUXILIARY NEWS

The Women's Auxiliary to the Sedgwick County Medical Society entertained with a tea at the home of Mrs. R. M. Gouldner in Wichita on February 8. A musical program furnished the entertainment. The regular board meeting was held preceding the tea.

The Marshall County Medical Auxiliary held a meeting on January 28 and re-elected the following officers: President, Mrs. W. R. Breeding of Marysville; Vice-President, Mrs. M. A. Brawley of Frankfort; Secretary, Mrs. R. L. McAllister of Marysville and Treasurer, Mrs. C. M. Newman of Axtell.

The Wyandotte County Medical Auxiliary will entertain the members of the Jackson County Medical Auxiliary at the home of Mrs. Earl R. Millis in Kansas City at the regular February meeting.

NUTRITION NOTES

"Eating for health" is a government-sponsored war campaign. It should also be an individual every-person-sponsored campaign long after the war is won.

Protein foods are essential to the diet because protein builds and repairs body tissues. Protein foods include milk, cheese, dried beans, eggs, and meat.

Mashed and riced potatoes are not so nourishing as baked potatoes or those boiled with the jackets on. Skins left on the potatoes prevent oxidation of the vitamins.

Only one-fourth of the families living in the United States are properly fed.

Because they do not get the food they need, there are forty-five million persons living in the United States who are below the health safetly line.

The ten big science stories and achievements of 1941, selected by Watson Davis, director of Science Service, are:

1. The radio locator of attacking airplanes developed and put into war use.
2. The enrichment of white flour and bread with vitamins and minerals.
3. The "cure" of gray hair in humans by daily doses of one of the B vitamins, para-aminobenzoic acid.
4. The great aurora of September 18.
5. The production of more and larger airplanes for war use.
6. The development of sulfadiazine spray treatment of burns.
7. Evidence that fowls constitute a reservoir for encephalitis or sleeping sickness and that mosquitoes carry the virus.
8. Evidence that infantile paralysis may be spread by flies.
9. Production of magnesium for airplanes by "mining" sea water.
10. Development and construction of a new type of cargo ship, Sea Otter II, welded and powered with auto engines. —Science Service.

"Time stays long enough for those who use it."—Leonardo de Vinci.



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FUNDAMENTALS OF PSYCHIATRY VI

THE PSYCHOSEXUAL DEVELOPMENT

William C. Menninger, M.D.

Topeka, Kansas

A knowledge of the development of the personality is fundamental in understanding mental health and ill health. This development begins perhaps even before the child is born, or certainly no later than at the time of birth. The growth of the individual through the infancy and childhood periods can be considered from two angles: First, the inherent internal forces (i. e., the will to live, to express himself, to find gratification) that are a part of the infant's endowment at birth, and second, the modifications of these forces demanded by the environment, namely, by the parents, the siblings, the economic situation, and many factors in the external world. A knowledge of the nature of these internal forces or drives and how the environment requires their modification gives us an explanation of human behavior in its varied expressions in both health and disease.

THE PLEASURE-PAIN PRINCIPLE

When the infant is born into the world we can be sure that he has no interest in the world except to selfishly gratify his own cravings. He has certain instincts at birth and the demand to satisfy these is his only motive in life. In his early months the infant gives nothing to anyone else, he makes no attempt to please anyone, and in short, is interested only in receiving what he wants. One may say that he follows the path of gaining all the pleasure he can and so far as possible avoiding displeasure and pain in any form. This pattern of behavior is governed by what is termed the "pleasure-pain principle," which indicates that all effort is directed toward obtaining pleasure and avoiding pain, regardless of the consequences. The term "pain" refers not only to physical suffering, but also to every other sort of displeasure, unhappiness, and discomfort.

During the major part of the first year of life the infant's chief interest and form of gratification is concerned with getting his food. Nothing else is of much importance and one can see that the whole life of the individual is bound up with this one source of satisfaction. Toward the end of his first year a new interest appears. Usually through the efforts of his parents to institute control of his excretions the child's attention is focused on these processes and they become his chief bodily interest, replacing to some degree the previous interest in using his mouth. This process of evacuation becomes the chief focus of bodily attention and remains so through the second year and usually the third. At about the age of three years the little child's interest turns to a curiosity about his or her sexual organs, their function, how they differ from those of others. One must conclude that this body area then becomes of paramount interest to the child.

Thus, the child initially develops a form of gratification centered around a particular part of his body, his mouth. Later the interest shifts to another part of the body, the anus, with the relinquishment of much of the interest in the first part. Finally a third source develops, the genitals, and in each of these the child receives a particular type of satisfaction. Because these areas of the body are sources of gratification they are termed the "erogenous zones," namely, the oral, anal, and genital zones. The interest which the child invests in these areas comes from an inherent force within himself termed the "libido." As the individual develops further this "libido" or interest gradually shifts from his own body to other people and to external objects.

The study of the investment of this interest and the shifts from one source to another in the infant and child serves to explain many of the character traits of the adult. It is possible to detail many factors which determine the amount of gratification obtained from each source. For instance, the little baby soon learns that he cannot have his milk at a certain moment, or his mother may not pick him up just at the moment he wishes. Thus, he is early introduced to what is termed "frustration," a denial or a disappointment. The frequency or the severity of the frustration determines in some degree the

amount of gratification a child may obtain from any particular source.

It is not possible to say that the child passes from the oral phase of gratification to the anal phase at a certain age. There are no lines of demarcation separating one period from another. Nevertheless, it is possible to outline the various characteristics in each of these stages, and the evolution of growth through these periods is referred to as the "psychosexual development." It is psychical development because it refers to the forms of psychological gratification. It is sexual development because it concerns various parts of the body as a source of gratification. It will be apparent that the word "sexual" in this connection is obviously a much more inclusive term than the layman ordinarily considers it.

POPULAR IDEAS REGARDING SEXUALITY

One cannot go very far in the study of psychiatry without bumping into the subject of sexuality, its significance in the life of every individual and its relation to this entire development. Consequently, it is desirable to re-orient the reader as to what the psychiatrist refers when he speaks of "sexuality," and to point out misconceptions about this subject existing in the mind of the average layman.

The average laymen holds the conception that sexual feelings and desires begin at puberty, a misunderstanding which will be cleared up as we progress further in this discussion. Furthermore, the average person believes that childhood is "unsullied" by sex and that any manifestations of sex curiosity or behavior represent some kind of perversion. This universal misunderstanding has had many unfortunate results. Parents often feel that they cannot talk to a child about this matter because they themselves have been so warped in their attitude about it. Their own embarrassment makes them dodge the question or invent stork stories or resort to vague nonsense about the butterflies and the flowers. The average child is forced to pick up much of his sexual information from his playmates, and therefore most of us grow up with the conception that sexuality is something "naughty," "dirty," or "sinful," and that it must be either whispered about or better not spoken of at all. This attitude has resulted in an extreme denial of the existence of sexual feelings and desires in some people, or, on the other hand, an attitude and behavior which because of its extreme emphasis and interest in the subject, is equally pathological. Many individuals (even though they be intelligent) prevent themselves from considering the significance of sexual disappointments and frustrations in their lives. It is impossible for most persons to discuss the subject with a physician as freely as they discuss digestion or any other physiological function. There is no logical reason to assume that the physiological and emotional activities regarding this subject, so far as medicine is concerned, should be any different than those of any other body system. While the average individual can tell about his eating habits, his likes and dislikes of food, his appetite, his digestion and even his bowel habits, all without the least reluctance, he displays embarrassment, reticence, and sometimes even acute distress if approached about his sexual life.

THE INVESTIGATIONS OF SEXUALITY THROUGH PSYCHOANALYSIS

When the subject of sex is shorn of the overevaluation of emphasis placed upon it by the embarrassments and inhibitions of an individual, it is possible to determine many important relationships with regard to its function in life. Such an approach has been possible in psychoanalysis. In the analytic situation when sufficient confidence has been established the patient tells the most intimate experiences, desires, and phantasies of his life, the great majority of which are frankly sexual. As a matter of fact, it did not take psychoanalysis to show us that the ultimate aim of the life of any person is the mating process and procreation, that everything one does is related to this ultimate and most important function, whether it is making a livelihood, building a home, or developing a business. Stripped then of the veil with which prudish mankind has surrounded it, sexuality can be recognized as various kinds of pleasure-giving acts connected with the body. Psychoanalysis assumes that all pleasure-giving acts connected with the body are to be regarded as forms of sexual activity, some of them direct expressions of sexual desires, like kissing, and some altered slightly to conform to social regulations, like smoking.

From this point of view, psychoanalysis has shown further that the child does obtain gratification through various parts of his body, and that the methods employed are part of the development of every child. This infantile sexuality is present in normal children as every observant parent can testify. The little child is curious about sex. He investigates other children; the majority go through a period of infantile masturbation, either by actually playing with their genitals or jumping up and down on the bed, rolling on a pillow, or using many other forms. By the age of five or six years nearly every child has inquired as to where babies come from, and the great majority ask many questions about it. If left to their own solution children of this age construct various theories of birth: that children develop through some sort of impregnation through the mouth, or that the child is born through the anus, or that pregnancy results from some surface contact

like kissing. Futhermore, infantile sexuality can be reconstructed from recollections by adults, particularly from material gained from psychoanalytic patients. Almost every individual can remember early sexual experience which often may have made a profound and lasting impression.

Psychoanalysis has also demonstrated very conclusively that the sexual life and desires and interests of every individual inevitably assume a prominent role in mental sickness, particularly in the neuroses. Undoubtedly, the chief explanation of the frequency of this factor in mental illness is that it is due to the restrictions which civilization has placed upon this particular drive for gratification. In prehistoric men we can assume that they had no conflicts about sex; there was no need to regard it as "naughty," or "dirty." Even during the days of Pompeii and Rome there were far fewer restrictions on man's expression in this sphere than there are at the present time. But one cannot forget that nature hasn't changed much since that time even if man's superficial relationships have, and consequently, the necessity for handling this strong primitive urge in a world where it is so strictly regulated often results in maladjustments.

From the psychoanalytic point of view the behavior and language of the psychotic patient further support the importance of sexuality in the causation of mental ill health. As a part of his illness, a psychotic individual may reverse his development to return to a very primitive, infantile level, and as a consequence revert to infantile sexual gratification without embarrassment or hesitation. He may masturbate or play with his feces with obvious enjoyment. From such observations one must conclude that consciousness covers this most powerful of the instinctive drives with a very thin veneer.

THE INFANTILE (SEXUAL) MODES OR AIMS OF PLEASURE-FINDING

The chief sources of satisfaction for the infant are his mouth activities, his sphincter activities, and his genitalia. The methods he uses to obtain gratification from these are in all instances self-generated, self-stimulated. The adult finds satisfaction in contacts with external objects, reading, seeing other people, but the infant is his own subject. When one derives satisfaction from the stimulation of parts of his own body the process is termed "auto-erotic." The baby's gratifications are entirely "auto-erotic," and one can make a long list of such methods, e. g., sucking, biting, touching, rubbing, defecating, urinating, looking (voyeurism), showing (exhibitionism), and rhythmical muscular activities.

Later on, beginning usually about the fourth or fifth year, the child begins to find pleasure from sources other than his own body, namely, from toys, from his playmates, his parents. Thus, the "psychosexual development" of an individual can be considered both as to methods which the individual uses to gain gratification and as to the choice of objects. We shall first consider the various stages with regard to the methods which the child uses.

In presenting these stages of psychosexual development, it is desirable to emphasize the fact that the various manifestations presented below represent "development". They are the phases of growth and are common and normal experiences to every person. They only become abnormal when the person fails to progress on to the next stage in his evolution (fixation) or when he slips backward from progress he has previously made (regression).

The Intra-Uterine Stage: To assume that a child obtains gratification while in his mother's uterus is speculative. Nevertheless, we can recognize that in this state the child has no tensions whatever. His needs are constantly fulfilled; he makes no investment of any sort in anything outside himself, a status which we refer to as "complete primary narcissism," (this term will be more fully explained later). This Utopia is interrupted by birth, but that it must have had some influence in every person's development, is a legitimate assumption, since there is much evidence in the dreams of neurotic patients of returning to this status. Furthermore, those very severely sick individuals whose illnesses progress over many years, often reach a stage in which they are more vegetative than animated. They lie on the floor with arms and legs curled up (in much the same position as in the intra-uterine state), express no interest, and give no recognition that any external environment exists.

The Oral Stage: For perhaps the first year the child's chief source of gratification is the mouth, not only as an organ which permits the receiving of a liquid which lessens internal tension, but also as a method of taking in affection. For a period of a year at least, often a little longer, the child's chief interest in life centers around an event which happens every three or four hours, his feeding. We must assume that the events that occur during these most sensitive years of the individual's life have a tremendous significance later, and that any event which takes place with the frequency, with the obvious gratification or lack of it to the individual must in many ways determine subsequent events concerned with the taking in or the receiving tendencies of any individual. Furthermore, one must recognize that while the food itself serves as a source of gratification, the child also gets satisfaction out of the procedure of sucking. There have been conclusive studies to show that the children who have been bottle-fed are much more likely to be thumb-

suckers than those who are breast-fed, the explanation being that the breast-fed baby nurses usually about fifteen minutes, and the bottle-fed baby for about five minutes. To make up for the difference the child develops the habit of sucking his finger or a pacifier to obtain additional satisfaction.

One can distinguish two phases in this "oral stage" of development, an early or sucking phase, and a later biting phase. It must be presumed that in the earlier phase of sucking the child regards the breast as being a part of himself. Certainly he makes no distinction between the breast as part of his mother and the parts of his own body. It is only after some weeks, or perhaps even months, that the child may recognize the breast as an object which can be taken away from him. As he grows and demands more food and at the same time is developing teeth, the mother experiences the stage when the baby is inclined to bite. Particularly is this true when the milk may not be forthcoming as rapidly as the child wishes it, and in his impatience he tries to bite the nipple. Thus, it is recognized that the child is in a sense trying to eat the nipple, and in this way the process is a primitive kind of cannibalism. The biting is the result of resentment because the child is thwarted in gaining the oral satisfaction he wishes.

In the normal adult person there are many hangovers, many effects, many expressions from this period of his development. Usually the character traits of optimism and dependence are related to this period. There are those individuals whose chief interest in life is in dieting; those who are epicureans of the first order, people who all their lives regard eating as the most important thing they do. Smoking is another oral gratification in which the smoke inhalation is similar to the sucking and chewing the cigar or pipe represents the biting phase. Certain smokers will smoke only cigarettes, others only cigars, and others only a pipe. Smokers will often admit that most satisfaction is obtained from the chewing of the pipe, and similar to this particular form of gratification is the less common tendency of children and some adults to chew pencils. Oratory and singing are examples of gratification obtained through the mouth, and perhaps the most frank expressions are seen in gum-chewing and kissing, the latter particularly being regarded by a prudish individual as a sexual act.

Abnormal expressions (at least we may call them unhealthy expressions) of this developmental period of life can be seen in the two general types popularly known as "suckers" and "biters." Everyone is familiar with the individual who is continuously hanging on, sucking for all he is worth, getting everything from everybody that he can. Then there is the prototype of the later phase, the "biter," who is argumentative, vitriolic, sarcastic, and unpopular. Psychoanalysis has uncovered certain of the unpleasant and less desirable character traits resulting from difficulties which have arisen in the oral phase of development. These character traits so frequently found in the same individual have been grouped, and regarded as those shown by the "oral character," particularly impatience, hastiness, restlessness, and dependence. This phase of development has a very definite relationship to the *taking* or getting or receiving propensities of every individual. A good example of the oral character is the individual addicted to the use of alcohol whose bottle is almost literally a continuation of the original bottle and whose dependency and irresponsibility are usually infantile or childish in nature.

When one objectively surveys the habits of mankind, he cannot help but be impressed by the number of people whose gratification in life centers in some way around their mouths, whether it be in gossiping or lip-smacking, or whether one limits his observation to the frankly sexual usages to which the mouth is put. "I love you so much I could eat you up," is a common lover's phrase. And biting, chewing, kissing and sucking are among the most common partial techniques in the act of loving. All of these (in fact, all of the mouth activities as forms of gratification) are directly related to this important period in childhood, termed the "oral phase" of the "psychosexual development."

The Anal Stage: About the tenth or twelfth month in the life of the average individual the parents start him in the training of his urinating and defecating habits. For a period of many months, often a year or two, the child is placed on the toilet three, four, five or six times a day with faithful regularity. It is the intention of the parent to focus the attention of the child on this particular procedure, and it can be readily understood why any ceremony of this sort so often repeated, and upon which the parent places so much emphasis may become of considerable importance to the child. There are elements in the procedure itself which add tremendously to its significance for the child. Very early he learns that this business of urinating and defecating is a method he can use to gain love and approval, or at the same time to express vindictiveness and willfulness. In other words, he soon learns that it is one particular procedure in which he, the tiny infant, has power over the adult. Every parent is quite familiar with the situation in which the child will not do his duty regardless of persuasion, pleading, or even threats. Then, as soon as he is removed from the toilet he performs. In this way the child can express his disapproval or hate toward the parent. On the other hand, parents are equally

familiar with the situation in which the child is encouraged to "be a big girl" or to "be a big boy," and the child learns that by doing as they wish him to do he can gain the love and approval of his parents.

There are other elements of gratification in this stage of development which are of considerable significance to the child. One can observe that the child soon becomes intensely interested not only in the process but in the product. It is literally his first creation, and one can observe further that early in this training the child derives a very definite gratification through the expulsion of his creation. In a later phase his gratification is derived in part from retention, the holding on to his product. In both phases, he can rightfully have a sense of omnipotence, of power which is entirely his, that no one can take from him. The parent's emphasis on the importance of regularity and of cleanliness serves to instill these characteristics into the personality so that their varied expressions in adulthood are related directly to this stage of evolution in infancy.

The adult expressions resulting from the training and experiences in the anal phase of infancy are perhaps even more varied than the oral expressions because of the increased suppression as well as repression of this procedure. There are, however, many socially approved methods of expressing this interest in adult life, expressions directly related to the importance and the satisfaction attached to it during this infanrile period. Of these collecting, whether it be of stamps, china, books, or any other objects, is definitely related to this period when the child likes to accumulate and to hold on to his own product. Likewise, many of the fine arts are directly (even though distantly) connected with this interest. The child of six months or a year has no repulsions or no reticence in smearing his feces about his crib. At five or six years he finds another though very similar outlet in making mud pies, or standing in the sand or mud and feeling it under his feet or oozing between his toes. At about ten years of age he has a similar experience in modeling clay. And still later, the same gratification may be obtained in daubing paint. The average layman, or even physician, is unaware of the origin of such satisfactions—they are "unconscious." The associated links are stamped out of consciousness, but once they are pointed out, the similarities are apparent. Similarly, it is possible to relate many of the arts and crafts to the experience in this phase of the individual's life.

Many desirable character traits of the adult are related directly to the associated ideas concerned with this habit training in infancy. Thus, the bestowing of gifts may give very definitely a gratification similar to that experienced by the infant who pleases his parents by his performance on the toilet. Likewise, the development of such traits as perseverance and persistence are directly related to this stage. Orderliness, the necessity for cleanliness, and conscientiousness in one's duties are all related traits.

Likewise, the undesirable expressions of this training may be apparent in the individual. Collecting may become a mania with tremendous over-evaluation of the products or objects collected. Parsimony, particularly as it becomes avarice and miserliness is a hangover from this holding-on process, hoarding, and refusing-to-give attitude in infancy. Obstinancy has its origin from this phase of an individual's life, and although the adult may transfer his defiance or his irascibility or his vindictiveness to many objects in the external world, its origin can be traced to difficulties which occurred in the first three years of his life. Likewise, cruelty and meanness are expressions of distorted gratification derived from sphincter training when the child learned that he could offend or hurt his parents by soiling himself. In reality he was soiling them. The psychiatrist observes many manifestations of gratification obtained from the infliction of pain or discomfort "sadism." Even the layman is familiar with such suggestive expressions as "mud slinging," "white-washing," "painting things red," "messing things up," all of which are polite references to the sadistic tendencies derived from this infantile training period.

The Genital Stage: In every child at the age of three or four years there is a spontaneous awakening of sexual curiosity, and with it a certain amount of sexual excitement. The child manifests the curiosity by inquiries and investigation and the excitement through self-experimentation. All too often, this interest is met by rebuff or embarrassment on the part of parents with the result that most children learn early to believe that all things sexual are "naughty," or "dirty."

One may observe that the little child manifests his interest primarily in his own sexual organs (referred to as the "phallic stage" of development) rather than showing any sexual interest of an adult type in objects or persons outside himself. Many adults can recall "show-off" parries among the neighborhood children in their fifth, sixth, or seventh years. They may recall "playing doctor" or other types of sexual play with other children. It is in this phase that the child becomes curious as to the origin of babies. The observing parent is familiar with such queries as "Why doesn't mamma have the same things that daddy has?" "Will mine ever be as big as daddy's?" "Why does mamma sit down when she goes to the toilet?" These and many other evidences leave no doubt of the fact that normal children pass through a period when sexual curiosity and stimulation is of paramount interest.

The Latency Period: From approximately the age of five or six on to the age of twelve or fourteen the child does not develop any new interests in any part of his body, and, on the other hand, this period is passed with a minimal amount of sexual interest. He spends most of his interest in obtaining gratifications in his play and in his school work. One must presume that in the majority of instances the conflicts about sex which arose at the earlier age are excluded largely from the conscious mind, and that instead of the previously intense interest in himself, he develops genuine affection and love for certain people in his environment, particularly for his parents, his playmates, and his heroes or heroines.

The Adolescent or Pubertal Period: From the age of twelve or thirteen on to about sixteen or seventeen every individual goes through a renewed period of interest in himself. This is shown in many trivial ways, characteristically by the increased attention to appearance, care of the hair, fingernails, and teeth, using rouge, and in other expressions. In addition, the majority of individuals during this period of intense interest in themselves renew the attention to their genital organs, with the result that the majority of children, both boys and girls, experience a period of masturbation about this age. They are interested in other individuals like themselves—members of their own sex—and so it is the age for chums, gangs and organizations for boys and for girls. There is a gradual emergence from this autoerotic type of gratification to the adult method of finding pleasure, namely, through an interest in a person of the opposite sex.

The Adult Heterosexual Stage: If the individual successfully "grows up," he passes through the various stages of gratification outlined above and reaches the final adult phase when his interest and sexual desires are directed toward a member of the opposite sex. With it go all the characteristics of the genital stage of childhood, i. e., initiative, investigation, and creation.

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ACUTE IRITIS, ACUTE CONJUNCTIVITIS, ACUTE GLAUCOMA AND THEIR DIFFERERENTIAL DIAGNOSIS*

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In thinking of a subject for discussion for tonight I felt that the topic selected would be of interest and of benefit to consider.

ACUTE IRITIS

Iritis is an inflammation of the iris.

Iritis is frequently associated with inflammation of the ciliary body and is then called iridocyclitis,—the acute type of which presents the picture of acute iritis but with more marked symptoms. The etiology is the same as that of iritis. The chronic type of iridocyclitis or uveitis is an inflammation of the entire uveal tract (iris, ciliary body and choroid). The etiology is much the same and the symptoms much the same as that of iritis. Then we also have sympathetic ophthalmitis which is a serous or plastic inflammation of the uveal tract in one eye due to the effects of a similar inflammation in the other. This inflammation is almost always due to a traumatic iridocyclitis of the first eye as a result of a perforating injury. The symptoms as a rule are identical to those of iridocyclitis.

The etiology determines the clinical varieties of iritis, and may be classified as (1) syphilitic, (2) gonorrheal, (3) septic infection (a focus of infection such as of teeth, tonsils, sinuses, intestinal tract and genito-urinary tract, etc.), (4) rheumatic, (5) diabetic, (6) tuberculosis, (7) traumatic, (8) secondary, (9) sympathetic and idiopathic.

Symptoms of iritis are pain, photophobia, lacrimation, interference with vision, loss of luster of iris, turbidity of aqueous of the anterior chamber, may be deposits on the posterior surface of cornea and cornea sensitive, may be pus cells that gravitate to bottom of the anterior chamber (hypopyon) or blood (hyphema), and the pupil is contracted. Also there is always marked circumcorneal injection, and more or less conjunctival congestion.

Treatment: (1) atropine one or two per cent, (2) dionine one or two per cent, (3) local heat (moist hot compresses), (4) rest in bed, (5) protection from light, (6) foreign protein, and (7) treatment of the etiological factor. Paracentesis is occasionally done to relieve continued high tension if that is present or to effect a favorable course of the disease in obstinate cases, but as a rule operative measures are indicated only after inflammatory symp-

toms have subsided, for the purpose of remedying sequalae. These sequalae may include such serious conditions as seclusion of the pupil or annular posterior synechia with iris bombe, total posterior synechia, occlusion of the pupil, and glaucoma.

ACUTE CONJUNCTIVITIS

Conjunctivitis is an inflammation of the conjunctiva.

The varieties are:

1. Catarrhal.
 (a) Acute.
 (b) Chronic.
 (c) Follicular.
2. Purulent.
 (a) Ophthalmia neonatorum.
 (b) Gonorrheal.
3. Membranous.
 (a) Diphtheritic.
 (b) Non-diphtheritic.
4. Inclusion conjunctivitis and trachoma.
5. Phlyctenular.
6. Vernal and allergic.

For tonight's discussion, we will consider acute catarrhal conjunctivitis,—also known as acute simple conjunctivitis.

The etiology may be:

(1) Mechanical — foreign bodies, exposure to wind and dust, smoke, and intense light.

(2) Epidemic — in spring or autumn due to certain micro-organisms, usually the pneumococcus or Koch-Weeks bacillus. A conjunctivitis resulting from this type of infection is very contagious and is popularly known as "pink eye."

(3) Infection — through contact with fingers, towels, handkerchiefs, etc., of patients suffering from the disease.

(4) Exanthemata — accompaning or following measles, etc.

(5) Associated with coryza, hay fever, and grippe.

The symptoms of acute catarrhal conjunctivitis are: Itching and smarting sensations referred to the lids, and they feel hot, heavy and as though a foreign body underneath. There is more or less photophobia. The sight is blurred only when discharge gets smeared over the surface of the cornea. The secretions are at first watery, later mucoid, and in severer forms it is muco-purulent. The palpebral conjunctiva and that of the fornix are of a brilliant red color and are swollen. The bulbar conjunctiva is usually but slightly congested, but may be more marked in sereve cases. Also severe cases may have edema of the bulbar conjunctiva and small subconjunctival hemorrhages, and edema of the lids.

Treatment: (1) iced compresses, (2) irrigation of conjunctival sac with boric acid solution, (3) argyrol fifteen to twenty-five per cent or metaphen 1-5000, bichloride ointment 1-3000 or metaphen ointment 1-3000, and if the disease tends to become obstinate or chronic zinc sulfate solution (one-half to one gr. per ounce) is indicated.

ACUTE GLAUCOMA

Glaucoma is an important and common disease of the eye, which has for its characteristic sign an increase of intraocular tension.

Its varieties are: (1) primary, and (2) secondary. Primary glaucoma is that type that occurs without antecedent ocular disease. Secondary glaucoma is that type that occurs after or follows as a result of some pre-existing disease of the eye.

Primary glaucoma occurs under two forms: (1) congestive, and (2) non-congestive (usually spoken of as simple glaucoma). Congestive glaucoma may be acute or chronia.

Acute congestive glaucoma can be divided into three stages: (1) prodromal, (2) acute glaucoma, and (3) absolute glaucoma.

The prodromal state is present in most instances, but may, however, be absent. This stage is characterized by transitory attacks of diminution of vision, rainbow tints seen around lights, and the central portion of the cornea on careful inspection will be found to be clouded (from edema). The anterior chamber is apt to be slightly shallow and the pupil somewhat dilated and sluggish. The tension is slightly or moderately increased.

The stage of acute glaucoma (glaucomatous attack) is characterized by sudden onset, and the symptoms are rapid loss of sight, severe pain in the eye and radiating along the branches of the fifth nerve with violent headache, and sometimes nausea and vomiting. There is increased intraocular tension, the lids are swollen and the conjunctiva congested and chemotic, cornea steamy or clouded (due to edema) and it is insensitive (from pressure on nerve filaments), there is pronounced circumcorneal injection, the anterior chamber is shallow, the pupil is dilated and imobile, the iris looks dull, and the aqueous is sometimes turbid.

The stage of absolute glaucoma is the end stage of all types of primary glaucoma. With each succeeding attack the diminution in vision becomes greater, until finally blindness ensues; the condition is then known as absolute glaucoma.

Treatment (1) Non-operative (local and constitutional), miotics are the chief measure,—especially eserine and pilocarpine. Injection of morphine is also of value. Intravenous hypertonic saline or glucose and free catharsis are often employed. (2)

Operative. Iridectomy becomes imperative, in the acute type, if no improvement from non-operative measures. If the case is a chronic type some form of filtering operation is considered better. In absolute glaucoma, when there are repeated attacks of pain, enucleation is indicated.

DIFFERENTIAL DIAGNOSIS

The congestive form of glaucoma has been mistaken for iritis and conjunctivitis; the use of atropine in such cases has caused great mischief. In acute cases of glaucoma the violent headache and general constitutional symptoms have misled practitioners into a diagnosis of some general febrile disease or other general condition, at a time when active ocular treatment was urgent.

Iritis is frequently mistaken for acute catarrhal conjunctivitis. It would be an unfortunate error to mistake acute iritis for acute catarrhal conjunctivitis because it would delay prompt instillation of atropine.

The diagnosis of acute glaucoma as acute iritis would be most serious since the use of atropine is disastrous in acute glaucoma, while called for in acute iritis.

The differential points given below should prevent such errors.

ACUTE IRITIS

1. Iris swollen, dull and discolored.
2. Pupil small, gray, sluggish, irregular after use of atropine.
3. Anterior chamber of normal depth (deeper in serious form) and presents exudation.
4. Cornea transparent (may present deposits on posterior surface) and sensitive.
5. Ciliary (circumcorneal) injection; pink zone of fine vessels surrounding cornea and fading toward fornix.
6. Conjunctiva usually transparent.
7. Lacrimation but no discharge.
8. Tension usually normal (ossasionally altered).
9. Some ciliary tenderness.
10. Pain radiating to forehead and temple, worse at night.
11. Dimness of vision.

ACUTE CONJUNCTIVITIS

1. No change in iris.
2. Pupil normal.
3. Anterior chamber normal.
4. Cornea transparent.
5. Conjunctival injection, coarse meshes, most pronounced in fornix and fading toward the cornea.
6. Conjunctiva reddened and opaque.
7. Mucous or mucopurulent discharge.
8. Tension normal.
9. No ciliary tenderness.
10. Discomfort, hot, gritty feeling, but no real pain.
11. No interference with vision, except blurring caused by the discharge smeared over the surface of the cornea.

ACUTE GLAUCOMA

1. Iris congested, discolored, dull, periphery pushed forward.
2. Pupil dilated, oval, immobile.
3. Anterior chamber shallow and aqueous sometimes turbid.
4. Cornea steamy and insensitive.
5. Ciliary and episcleral injection (also conjunctival congestion).
6. Conjunctiva congested and chemotic.
7. Lacrimation but no discharge.
8. Tension increased.
9. Ciliary tenderness.
10. Severe pain in and about eye, with headache.
11. Marked dimness of vision.

The following slit-lamp findings are also helpful:

ACUTE IRITIS

Beam visible, and shows an aqueous "flare" and floaters (cells or clumps of cells or strands of fibrin).

ACUTE CONJUNCTIVITIS

Beam not visible

ACUTE GLAUCOMA

No beam visible if aqueous clear and not turbid. Beam is visible if aqueous turbid and has cellular elements, etc., in it. (Cellular elements, fibrin, and pigment granules are not infrequently found in the anterior chamber fluid.)

In inflammatory conditions of the eye, the findings of the slit-lamp may be of great value. With it we are able to see particles consisting of cells, clumps of cells (termed floaters) or strands of fibrin, in the aqueous when such are present. Also such exudates when present may be seen in the retrolental space and in the vitreous. The beam of light from the slit-lamp becomes visible as it traverses the anterior chamber when there are products of inflammation present in the aqueous—from such diseases as iritis, iridocyclitis, uveitis, choroiditis, and sympathetic ophthalmitis. The finding of this visible beam or flare and the presence of particles in the aqueous are often the earliest signs of serious inflammation of the eye, such as uveitis or sympathetic ophthalmitis, and the slit-lamp enables us to detect such formidable complications some days earlier than we could by the ordinary methods of examination.

The death rate for the United States registration area in 1939 was 10.6, the lowest ever recorded, according to a final report issued by the U. S. Bureau of the Census.

President's Page

PUBLIC AND LEGISLATIVE RELATIONS

To the Members of The Kansas Medical Society:

That merit alone can depend on its own reward is a fallacy well demonstrated by the present position of American medicine before the public and in the Federal and State legislative halls of this country. Probably the greatest achievement of the medical profession during the past fifty years has been the improvement in the competency of medical and surgical practice. The major portion of that progress has come through the achievement by ourselves of more stringent requirements of medical education, the abolition of numerous inadequate medical schools and the raising of the standards of existing medical schools to a high educational plane. Now, after fifty years of such progress, these standards—and with it, the high competency of medical practice—are being threatened on every hand by legislation permitting cultists with greatly substandard qualifications to practice medicine and surgery in full or in part. This in effect makes their schools, which are entirely unqualified to adequately train their students in medicine, diploma mills for the practice of medicine.

That such legislation receives any recognition whatsoever, is strong evidence of medicine's failure to properly educate the public on the subjects of medical schools and medical standards. The public is unaware of the high standards of medical schools as compared to the complete lack of such standards in all cult schools. The mass of hysterical exaggerations of the cultists concerning the qualifications of their schools is accepted by the public. Only continuous education of the public by the medical profession on the facts of the situation can avert a grave lowering of medical standards in this entire country, as well as in our own State.

Sincerely,

Henry N. Ticker, M. D.

President, The Kansas Medical Society.

EDITORIAL

THE OSTEOPATHIC SITUATION IN KANSAS

Again, with the convening of the Kansas Legislature, the semi-annual battle of the osteopaths to enter the field of medicine and surgery is brought before the public. Kansas is not the only state this year that is having osteopathic troubles as the states of Nebraska and Missouri have had similar osteopathic legislative measures presented. All three states are striving to keep the medical standards for the civilian population at the highest possible level.

The Kansas situation is best summarized by briefing the proposed osteopathic bills and their present status in the Legislature.

House Bill No. 40, the first bill introduced by the osteopaths, and published in the February issue of the Journal, died in the House Committee on Hygiene and Public Health.

House Bill No. 189 by Nickell and Bush, two osteopaths, an act concerning the practice of osteopathy, providing for educational requirements, examinations and licensing of osteopathic physicians, would amend section 65-1201 of the General Statutes of 1935, and repeal said original section. The bill was killed.

House Bill No. 293 has had a great deal of newspaper publicity. The measure was introduced by Representatives I. R. Nickell (osteopath) of Smith Center, W. R. Christian of Ulysses and R. I. Montgomery of Montezuma. This bill relating to the practice of osteopathy, providing educational requirements, examination and licensing of osteopathic physicians and surgeons, would have repealed and amended the original statutes. Representative Chas. Vance of Liberal offered an amendment to the measure which proposed that new examinations would be required for all osteopaths coming under the liberalization act, but the amendment was defeated. After an extensive debate, Representative Donald Stewart of Independence requested a standing vote to strike out the enacting clause of the bill, which resulted in a 60-40 vote, and the bill was therefore killed.

House Bill No. 366 was recently introduced by the House Committee on Hygiene and Public Health. The act, relating to the practice of osteopathy, authorizing certain licensed osteopathic physicians to administer and prescribe biologicals and to register and practice under the laws of the United States governing narcotics, would have greatly enlarged the field for osteopaths. On March 12, the vote came to strike this bill from the calendar but it was killed. The osteopaths then tried to advance the measure on the calendar (which requires a two-thirds vote), but the standing vote was 44-for and 40-against and this bill went into the legislative morgue.

OSTEOPATHS AND DOCTORS

The March 3 Kansas City Times published the following editorial regarding the osteopathic situation. The editorial has caused a great deal of comment in both Kansas and Missouri as well as Nebraska, as all three states are having their osteopathic legislative difficulties at the present time. As the editorial is such an interesting one we believed it should be read by all of our members.

"The bill introduced in the Missouri Legislature to give osteopaths the legal standing of physicians and surgeons and provide that they must be admitted to practice in any tax supported hospital, such as General hospital, in Kansas City, carries series implications that do not appear on the surface. It happens that the bill has the initial advantage of having been introduced by the personally popular Dr. S. E. Still, a man of good standing and a leader of the osteopaths of the state.

"Offhand, this bill might strike the average person as of little consequence. But it would be a load of dynamite under the practice of medicine in this state. By forcing the admission of osteopaths to practice in General hospital the Legislature would give them a privilege that no physician or surgeon can claim automatically today. The hospital has been built up to its present high standing by careful selection of its staff of 166 doctors who give their time free. To apply his healing art at General a doctor must have more than a degree. He must have proved himself by his work. Pass this bill and the weakest osteopath in the city would have a standing that all doctors have been required to earn by their own efforts.

"It is only by its high standards and selection of doctors that General hospital has been able to build up its service to the public and its reputation throughout the country. Throw the doors wide open to any group (even to all doctors) and the reputation can be expected to go out the same doors.

"Worst threat of all is the danger that General hospital would lose its class A standing. This would simply mean ruin. Without that standing it could not get interns or nurses. It is unlikely that the 166 high standing doctors would continue to offer their services. This same danger applies to every tax supported hospital in the state. Right or wrong, the classification of hospitals is in the hands of four

powerful associations and boards in the national medical profession. The disapproval of any one of them would be the death warrant for a hospital.

"Of course, the whole assumption in such a proposal is false. You can't make physicians and surgeons by passing a law. Out of the centuries the medical profession has gradually created the high standards of training that protect the public as far as possible from incompetent men. Today a man is a physician or surgeon because he has met those standards as far as examinations can prove them. Some osteopaths have also met the medical requirements; but the fact stands that a man can become an osteopath with only a fraction of the training required of any physician or surgeon. And his training is in a different profession. To ask that he be made a physician by law is simply asking for the law to say what isn't so.

"The best hope to eliminate all the confusion is in the basic science bill introduced in the House by Roy Hamlin of Hannibal. It would require that anyone practicing a healing art (except Christian Scientists) be able to pass examinations in anatomy, pathology and other basic sciences. With such a law osteopaths would be required to have a large part, but not all, the training required of physicians. Such a law would assure the public that anyone practicing a healing art should have a real basis for diagnosis and treatment of a disease. For those who believe in osteopathic treatment, it would be assurance that the osteopaths of their choice were well grounded in their profession. And it could eliminate most of the argument about who should practice. If the osteopaths are really physicians, as the Still proposal implies, they should have no objection whatever to the basic science bill.

"The members of the Legislature were elected to represent the public. The protection of the public calls for the highest possible standards for all persons holding themselves out as doctors. Personal friendship, even in the Legislature, is a private matter between individuals. It has no bearing on the merits or demerits of a bill before the House.

"If the House members feel justified in passing a law to call osteopath physicians then they should go all the way with their convictions and pass the basic science bill."

MEDICAL SOCIETY PREPAYMENT PLANS

In the swiftly changing world of today many roads are open but the one marked status quo is closed. If the medical profession does not choose where it will go, less competent powers will choose for it.

The American Medical Association through its House of Delegates and some twenty state medical societies has already chosen the road of medical society prepayment plans. It is not an easy highway. It is an almost uncharted track through difficult and little known territory. But medicine has been hewing out that sort of hard passages for many centuries in its campaign against disease. There have always been quislings and quacks who claimed to know easier and more pleasant ways than those mapped by the physicians.

Politicians know that the achievements of medicine have made medical care one of the most highly prized assets of modern civilization, and they are now trying to grab that asset and use it as trading stock for votes and political power. The medical profession knows that medical care so-used loses much of its value.

Medical society prepayment plans offer a way to put this asset at the service of the public, without thus destroying its value. The medical profession is little interested in methods of payment if these are sufficient to maintain medical education, research and the other elements which have made American service the most effective in the world in fighting disease. That profession is interested to see, in the words of the first of the Ten Principles adopted by the House of Delegates, that "all features of medical service in any method of medical practice should be under the control of the medical profession". With that principle assured medical societies have whole heartedly cooperated with almost every type of social organization, and have greatly improved both medical service and administration under public health, workmen's compensation, care for the indigent, maternal and child health care, Farm Security Administration and almost innumerable local organizations. Even though financial arrangements were often unsatisfactory, the medical profession insisted that the service should be under medical control and be kept up to professional standards. The difficulty in doing this suggests one reason for starting prepayment plans by a medical society. Political and lay prepayment plans fix their income by what taxation will be borne or what subscribers will pay, and then cut the service to fit the available cash, usually also cutting the physicians' income below what will maintain standards while nearly always promising a "complete medical service", depending upon the incapacity of patients to judge the service to get away with the deception.

Whenever the administration and standards of any phase of medical care have been entrusted to politicians or persons untrained in medical science and art, or wherever financial management has en-

croached upon the control of medical service that service has deteriorated and the sick have suffered. This was true of public health, of institutions for the mentally diseased, and of whole nations under compulsory sickness insurance.

Medical society prepayment plans dare not deceive the public. They must meet equally the difficult problem of determining just what premiums can be collected and then just what service can be given for these premiums and finally just how this relation can be fully and honestly explained to the subscribers. Because this is but one of many hard problems of an honest effort to conduct a prepayment plan there have been many experiments, some of which failed, and numerous first mistakes to correct, so that some have grown fainthearted in the fight to organize and conduct such plans.

Yet in a short time about 600,000 persons have received the medical protection of these plans and the number of plans and subscribers grows daily. So greatly do prepayment plans giving an honest medical service change the desire and demand for medical care that figures based on plans with a fixed premium and more or less secretly restricted service furnish little useful actuarial information. Only experiments with medical society service prepayment plans can determine just what services can be honestly promised and then actually given when the medical care is maintained at the high professional standards demanded in medical society plans.

Today much experimenting has been done by plans now in operation and many of the facts both for successful financial operation and satisfactory service to subscribers have been determined. It is now a question of development during the short time that the road is still open for choice between political or lay controlled plans, and those in which medical standards are established and maintained, as they always have been established and maintained by the medical profession. Medicine still has a chance to choose, but that chance is disappearing.

Events in nearly all the countries involved in this global war have forecast extensive social changes when the eagerly awaited peace arrives. Medical arrangements will not be isolated from those changes nor can organized medicine remain indifferent to them without risking the achievements of many centuries. Moreover, since medicine is the social trustee of public health it can reject this opportunity and duty only by betraying that trusteeship.—A. M. Simons, Assistant Dicector of the Bureau of Medical Economics of the American Medical Association.—Virginia Medical Monthly.

Buy United States War Bonds and Stamps

VICTORY NURSES

The proposed program for the enrollment and training of Victory Nurses is sound. It should have a definite appeal to young women who desire to serve their country in a useful way. It meets all necessary requirements for the education and training of the nurses who are so vitally needed.

It would be a sad commentary upon our young women, upon the nursing profession and upon our hospitals, if any reasonable program for supplying our armed forces as well as the civilian population would fail for lack of interest. It would be criminal if such a program would fail for lack of cooperation.

More and more the winning of the war becomes dependent upon a larger participation by the women of our country in every phase of the war effort. No single activity should have a stronger appeal to young women. There is no greater sphere of usefulness than nursing the sick and wounded men and women of our armed services.

Under the plan the Government will provide a reasonable stipend for payment of the tuition of the student nurse during two and one-half years of training, and the hospital will provide maintenance. The last six months she will serve in the hospital at a salary at that time current for nurses of similar training.

Hospitals should actively engage in recruiting student nurses who can be adequately trained as soon as the proposed program is approved and the necessary funds appropriated and made available.

Differences of opinion that have delayed action seem to have been compromised and there is but one more action to be taken to accomplish the desired result, that is, the appropriation of Federal funds in a sum sufficiently large to insure early and satisfactory success of the proposed plan. Under the proper auspices and with the sponsorship of the hospitals and nursing profession the young women of the country can be depended upon to enroll in sufficient numbers to fill all the classes.

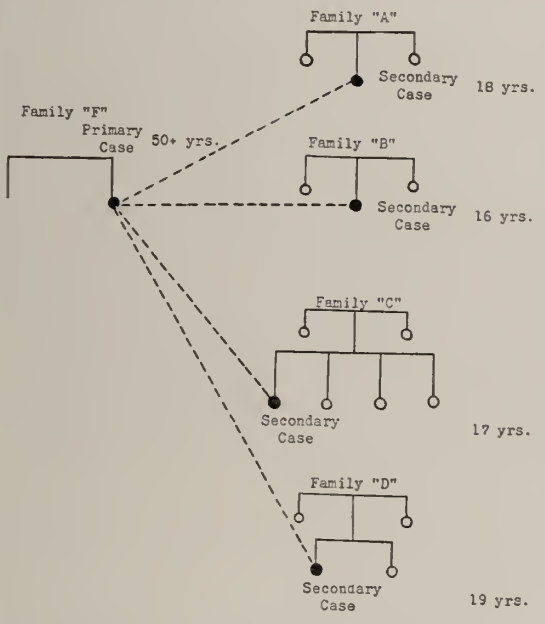
One word of caution should be suggested. There are always those who will find some fault with any worth while program, something to criticize, something to oppose. There are those among us who see in this program an effort of Government to direct and control nursing education. There is but one answer to this criticism—if the Federal Government ever controls nursing education, it will be the fault of the nurse educators and the hospital training schools; it will not be because the Victory Nurse program lacks merit or for any sound reason that it should not be adopted.—Hospitals.

TUBERCULOSIS CONTROL

PULMONARY TUBERCULOSIS RESULTING FROM EXTRA-FAMILIAL CONTACTS

In mass surveys there is not the opportunity for individualization of cases that is necessary to discover extra-familial sources of tuberculous infection. Rural communities with low death rates have afforded excellent opportunities for demonstrating the importance of extra-familial contact in the spread of tuberculosis in the community.

In Massachusetts a five-year survey on the control of tuberculosis was recently conducted in a county considered to be representative of a rural New England community, and with next to the lowest death rate from pulmonary tuberculosis of any county in the state.



It was during this survey that attention was focused on the importance of extra familial contact. The diagram here shown is a graphic representation of the spread of tuberculosis among several families in the same community. The discovery of the source of infection required a considerable period of time and a careful evaluation of certain obscuring factors.

In March, 1935, and August, 1936, two cases of pulmonary tuberculosis were reported in a small community of approximately 4,000 persons. Both cases were high school girls, aged eighteen and sixteen, respectively. They were the only young persons in their respective homes. Members of family "A" were examined and were found to have no evidence of tuberculosis. Family "B" refused examination at the time, but were subsequently examined and found to be negative for tuberculosis. There was no history of tuberculosis in either of the families. Both households used raw milk from tuberculin-tested herds, but obtained from different dairies. The two girls were not "chums" but attended the same high school.

A check with the school physician revealed that none of the teachers had tuberculosis, with the possible exception of one. She had suffered from pulmonary tuberculosis two years prior, but was discharged from the sanatorium as an arrested case. However, because several of the pupils complained that this teacher coughed during her clasess, several sputum examinations were made by the school physician, all of which were found to be negative.

The situation rested at this stage until April, 1937, when a nineteen year old girl, graduated from the same high school in 1936, was found to have tuberculosis. Careful inquiry revealed that she had little or no contact with either of the other girls at the school. She had, however, taken two courses given by the teacher who was under suspicion. A check-up by x-ray in her family showed no evidence of active tuberculosis, nor was there any family history of the disease.

Again the evidence pointed to someone in the high school as a potential source of infection for these three girls. The teacher, aware that she was under suspicion, returned to the sanatorium for a check-up. A negative report was received by the school physician from the sanatorium.

In December, 1937, a fourth girl, aged seventeen, was found to have pulmonary tuberculosis. She too, had had the same teacher in some of her classes. She knew all three of the girls but denied close friendship with them. Her family was examined by x-ray by a local physician who reported negative findings. Subsequent examination of these films confirmed the original report. At this stage there seemed to be almost overwhelming evidence that these girls had had a common source of infection, and the logical place to search seemed to be in the high school.

Further visits were made to the families to recheck their contact histories. They had all used raw milk from tuberculin-tested herds, but only two of the families took milk from the same dairy. During one of these visits to family "C" a casual remark opened a new approach to the problem.

It was found that all four families attended the same church. This was a remarkable coincidence. A rough statistical calculation placed the church under strong suspicion on the basis that in the school

population considerably less than one-half of one case would be expected to have occurred by chance among this religious denomination if the source of infection were in the school. Inquiries regarding attendance of the girls at the church, revealed that three of them sang in the choir and all four of them had attended social functions on numerous occasions.

A careful check-up of the reported cases and deaths in the community failed to show any of them to be members of this church. However, during the investigations relative to the church membership it was learned quite by accident that the wife of the former minister had developed pulmonnary tuberculosis and had entered a sanatorium in another state within three months after leaving the parish, early in 1936. This rumor was checked and found to be authentic. In fact, at the time of admission to the sanatorium the minister's wife was found to have tuberculosis in an advanced stage and her sputum was markedly positive.

Further inquiry revealed that the minister's wife also sang soprano in the choir and took communion from a common cup before three of the girls who sang in the choir, as well as before the fourth who was not a choir member. Thus, a common source of infection was found for these four girls in their fellow church member. On the basis of x-ray, sputum examination and statistics, the school teacher, an arrested case, was eliminated from suspicion.

Aside from determining the true source of infection for these four girls, several other factors of epidemiological significance are manifested. In this particular instance, the range of age was from sixteen to nineteen years and all cases were girls, again revealing the importance of age and sex. However, there is also evidence at the present time to show that the age of highest mortality from tuberculosis is gradually shifting to the older age groups.

A further factor of importance is that three of these girls had positive sputum at the time diagnosis was made; two of them were moderately advanced and two far advanced at the time of diagnosis.

There was a high fatality rate. Two of the girls have died; one remains in a sanatorium and the fourth has been discharged from the sanatorium as an arrested case.

Although three of the girls sang in the soprano section of the choir, there was ample opportunity for contact between the fourth girl and the minister's wife through social functions and Sunday School. These contacts were regular, usually once or twice a week, over a period of several years.

The question of the common communion cup is a moot one. It is reasonable to suppose that droplet infection through contact at choir practice and social functions might well be sufficient to result in active disease. The dosage of infection was probably large if consideration is given to the cumulative effect resulting from frequent exposures at fairly regular intervals.

Failure to find the source of infection within a household should not preclude further attempts at finding the source case. — *From Tuberculosis Abstracts for March, 1943. Pulmonary Tuberculosis Resulting from Extra-Familial Contacts, C. W. Twinam and Alton S. Pope, Amer. Jour. of Pub. Health, November, 1942.*

NEWS NOTES

STATE MEETING

In accordance with the decision of the Council the 84th Annual Meeting of the Kansas Medical Society will be limited entirely to a business session because of war time situation and will be held on May 8 and 9, in Topeka. Those attending the meeting will be limited to officers, delegates and such committee chairmen or other members who have problems or reports to be presented before the House of Delegates. Since, because of the war conditions, there are several difficult problems continuously before the Society, it is hoped that every county society will select its delegates and have them present without fail at this meeting.

Two business sessions will be held. The first meeting of the House of Delegates will be held Saturday evening, May 8 and the second, Sunday morning, May 9. If conditions permit it is planned to hold a dinner meeting Saturday evening, May 8, which will adjourn directly into the first House of Delegates meeting.

The April issue of the Journal will publish as much of the official proceedings of the Society as possible to facilitate the work of the House of Delegates meeting. All officers, councilors and committee chairmen are, therefore, requested to send in their reports to the Journal office as soon as possible, as the April issue will go to press the first week in that month.

In making your hotel reservations, please make them as early as possible, mentioning that you are attending the State Meeting of the Kansas Medical Society, as both the Kansan and the Jayhawk Hotels have been contacted in this regard, or if you have difficulties in securing your reservations contact the central office direct.

NEW 1943 ARMY QUOTA

The 1943 recruiting program of the Surgeon General of the Army calls for the commissioning of 6,900 physicians and approximately 3,000 hospital interns and residents, it is reported in the The Journal of the American Medical Association for March 13 in an outline of the new procedure of processing physicians, dentists and veterinarians for the Army. The program also calls for the commissioning of 4,800 dentists and 900 veterinarians.

Physicians will be procured from the following twenty states and the District of Columbia: California, Colorado, Connecticut, Illinois, Iowa, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont and Wisconsin.

Give the cigarette they prefer to get*



IT'S EASY to understand why cigarettes are the preferred gift in the armed services. But did you know that among them the best-liked brand* of cigarette is Camel? Camel is the popular choice of millions and millions of smokers for its finer flavor and superior mildness.

Send Camels, the service man's favorite, to those friends or relatives who are fighting our battles —fighting them efficiently and unselfishly. Your thoughtfulness will be appreciated.

Tobacco stores feature Camels by the carton. See or telephone your dealer today.

Remember, you can *still* send Camels to Army personnel in the U.S., and to men in the Navy, Marines, or Coast Guard *wherever they are*. The Post Office rule against mailing packages applies only to those sent to the overseas Army.

* With men in the Army, the Navy, the Marine Corps, and the Coast Guard, the favorite cigarette is Camel. (Based on actual sales records in Post Exchanges and Canteens.)

Camel

costlier tobaccos



The following states have already contributed more physicians to the armed forces than the sum of their 1942 and 1943 quotas and will not be called on to furnish any more physicians, except interns and residents and except special cases for specific position vacancies, during 1943: Alabama, Arizona, Delaware, Georgia, Idaho, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, South Carolina, Tennessee, Texas, West Virginia and Wyoming.

It is stated that at present there will be no procurement of physicians, except interns and residents and in special cases for specific position vacancies, in those states not listed above. There will be no procurement of dentists, except special cases for specific position vacancies, in the following sixteen states: Alabama, Arizona, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and Virginia.

At the present time there are no restrictions on the recruiting of veterinarians.

In the instructions issued by the Army it is pointed out that the Surgeon General has discontinued all medical officer recruiting boards and that under the new procurement program no physician, dentist or veterinarian will be commissioned in the armed forces of the United States until he has been declared "available" by the Procurement and Assignment Service of the War Manpower Commission.

In each state the Procurement and Assignment Service has set up three state chairmen: Medical, dental and veterinary. Each of these prepares a monthly quota list of physicians, dentists and veterinarians who are apparently suitable and who are available, for commissioning in the Army of the United States. This list is submitted to the central office of the Procurement and Assignment Service which sends a communication inviting such individuals to apply for service with the armed forces. On the reply card enclosed with the invitation the individual states his preference for the Army, Navy or Medical Department of the Air Forces. These reply cards are sent by the potential applicants to the state chairmen of the Procurement and Assignment Service who in turn submit lists of such potential applicants to the Officer Procurement Service of the Army.

On receipt of such lists the officer procurement district office contacts the potential applicant and arranges for an interview regarding a commission.

Applicants will be requested by the officer procurement district office to complete all papers and take all steps required of them within fourteen days of the date of such request. If this is not complied with, a report thereon will be transmitted by the officer procurement district office to the state chairman of the Procurement and Assignment Service.

The decision as to the grade and appointment to be recommended for each candidate rests with the Surgeon General, not with the Officer Procurement Service.

DR. HASSIG HONORED

Dr. J. F. Hassig of Kansas City, Secretary of the Kansas State Board of Medical Registration and Examination, was elected President-Elect of the National Federation of Medical Education and Licensure, at the Annual Congress of the organization which was held in Chicago on February 14 and 15.

Dr. Hassig was at one time President fo the Kansas Board, and following the death of Dr. Charles H. Ewing of Larned the Secretary, succeeded him as secretary, which position he has held ever since. He has also held many positions of trust in our state organization and was at one time its President.

WAR SESSION MEETING APRIL FIRST

New developments in military and civilian medical and hospital service will be brought to members of the medical profession at large, and hospital representatives, through a series of twenty War Sessions, beginning March 1, to be held throughout the United States under the sponsorship of the American College of Surgeons with the cooperation of other medical organizations and of the Federal medical services.

The Kansas City, Missouri, meeting is scheduled to be held at the President Hotel on Thursday, April 1.

Each War Session will consist of an all-day program, lasting from 9:00 a.m. to 10 p.m., including luncheon and dinner conferences. There will be eight meetings in each session, four of which will be for the entire assembly, and the remainder divided into two meetings each for physicians and for hospital representatives. Subjects will be similar in the different places but some of the speakers will be changed in the different states and service commands. Nationally known representatives of the United States Army, the United States Navy, the United States Office of Civilian Defense, the United States Procurement and Assignment Service, and the United States Public Health Service, will address the meetings and will lead discussions, in addition to participation by prominent leaders in civilian medical practice and hospital service.

Topics to be discussed relating to military medicine will include care of the ill and injured in combat zones and after evacuation. The newer types of injuries encountered in this war, such as crush and blast injuries, will be especially considered, together with prevention and treatment of infections, and treatment of burns, shock, and injuries of specific parts of the body. Anesthesia, plastic surgery, and the psychoneuroses of war, will be some of the other topics. Problems of civilian medical care in wartime which will be discussed will include the responsibilities of individual doctors and hospitals; personnel problems of hospitals; organization of emergency medical services; maintaining adequate supplies, furnishings, and equipment; maintenance of high standards of medical and nursing education, and of hospital service in general; hospital public relations; and administrative adjustments in professional staffs of hospitals. The opening meeting of each session will be devoted to discussion of "Medical and Surgical Aspects of Chemical Warfare," led by a representative of the United States Office of Civilian Defense, and the closing meeting will be a panel discussion on problems in wartime civilian medical practice to be led by representatives of the United States Public Health Service, the American College of Physicians, the American Medical Association, medical services in industry, and the American College of Surgeons. Some of the topics for consideration at this meeting will be endemic and epidemic diseases, including tropical diseases; medical services in industry; medical and surgical practice; and supplementary postgraduate education for medical officers and civilian doctors.

Dr. Irvin Abell, Chairman of the Board of Regents of the College, in announcing the War Sessions, said that although participating states and provinces for each meeting have been designated to facilitate arrangements, there will be no geographic restriction on attendance, and those who plan to attend may select the place and time which are most convenient.

KANSAS

CROSSROAD OF THE POST-WAR WORLD

The construction of great air training facilities throughout Kansas has forcefully demonstrated the presence of two great resources that mark this state's future.

A growing air transportation system, servicing Europe, Asia, South America, Africa and Australia, will demand these resources. The air-highways of tomorrow will seek terminals where there is the best flying weather and the best geographical attributes—which Kansas has proved it can supply.

It also is possible to add other resources. Kansas already has the giant runways. The factories to be used in servicing such aircraft are now turning out more war units than did the entire nation in 1941. Kansas agricultural products may be handily adapted to air transport by means of dehydration, thus affording markets on every continent.

That is the vision. The events of the next years and the combined effort of Kansans will be the determining factors.

KANSAS
INDUSTRIAL DEVELOPMENT COMMISSION

The American College of Surgeons cancelled its 1942 national meeting and is holding in abeyance plans for a Clinical Congress in 1943, in the meantime offering the regional meeting plan provided by the War Sessions to save the time of the doctors and other personnel, and to minimize transportation difficulties, without sacrificing unduly during wartime the educational and stimulative benefits of medical assemblies.

MAJOR DIXON RETURNS TO TOPEKA

Major H. J. Dixon, formerly in charge of the Kansas Medical Officers Recruiting Board, located at Topeka, has recently returned to Topeka where he is Executive Officer, assistant to the Commanding Officer of District No. 4 of the Seventh Service Command. The district offices are located in Room 1202 National Bank of Topeka Building.

Major Dixon and Major R. W. Vandeventer were of great assistance to Kansas physicians while in charge of the Procurement and Assignment of Physicians for the state and both are well known to many Kansas members. When the Procurement office was closed on October 26, Major Dixon was transferred to Fort Leonard Wood, Missouri.

NEW RED CROSS DIRECTOR

Dr. Albert McCown, National Director of the American Red Cross of Washington, D. C., has advised the central office of the recent appointment of Dr. G. Foard McGinnis as Director of Medical and Health Service of the Midwestern Area of the American Red Cross. Headquarters will be maintained in St. Louis, Missouri.

Dr. McGinnis comes to the Red Cross from the Tennessee Department of Public Health, where he has been Director of the Venereal Disease Control Service since 1929, Associate Professor of Preventive Medicine of the University of Tennessee and Chief of the Department of Syphilology of Meharry Medical College.

KANSAS HOSPITAL ASSOCIATION MEETING

The Kansas State Hospital Association held a one day meeting at the Allis Hotel in Wichita on Tuesday, March 2. The session consisted of scheduled morning and afternoon meetings with talks on important hospital problems of the war emergency.

Mr. James Hamilton, President of the American Hospital Association of Philadelphia, Pennsylvania, appeared on the program. Mr. Hamilton has recently been appointed Director of the American Hospital Association Wartime Service Bureau in Washington, D. C.

WYANDOTTE COUNTY NEWS LETTER

The Wyandotte County Medical Society has inaugurated a news-letter to its members in service. News-letter No. 2 is now off the mimeograph machines and will probably be as welcome as letters from home to the men in the armed forces.

Dr. O. W. Davidson in the Huron Building, Councilor for the Second District is the editor of the letters. Newsletter No. 2 is out and No. 3 is in the making. The first letter to be sent appeared soon after the holidays. It was several pages long and contained professional, personal and service news, written humorously and cleverly. Personal addresses for service men are carried from time to time and news of men in foreign countries, the kind of news that is most interesting but according to government ban is restricted in printed periodicals.

LEGISLATIVE MEASURES

The medical profession is always interested in pending legislative measures and a number of these materially affect the profession. The following is a summary of the legislative measures now pending in the Senate or the House of Representatives and their status:

The osteopathic measures have been discussed in an editorial in this issue.

House Bill No. 25, An Act providing for the temporary registration of nurses in this state to protect the health of the civilian population. The bill has passed the House and is on General Orders in the Senate, with recommendations for passage made by the Senate Committee.

House Bill No. 92, An Act relating to consulting psychologists, creating a board of examiners. The bill was killed in the House. Senate Bill No. 81, a similar measure, is still in the Senate Committee on Federal and State Affairs.

House Bill No. 120 (Same as Senate Bill No. 94), An Act relating to persons who at the time of their entrance into the military service were registered or licensed to engage in or practice an occupation or profession in the state of Kansas, and providing that such licensees and registrants shall not be required to pay certain annual fees to the state of Kansas. The bill has passed both Houses and has been signed by the Governor.

House Bill No. 121, An Act relating to the examination and registration of doctors of medicine and surgery and the state board of medical registration and examination, and amending sections of the General Statutes of 1935. Has passed both Houses of the Legislature and been signed by the Governor.

House Bill No. 138, An Act relating to prenatal serological tests for syphilis, and prescribing certain powers and duties, is still in the House Committee on Hygiene and Public Health.

House Bill No. 139, An Act relating to marriage and providing examinations and serological tests of applicants for marriage license, and providing penalties, is still in the House Committee on Hygiene and Public Health.

House Bill No. 204, An Act providing for the payment for the services of student nurses at the University of Kansas Hospitals.

House Bill No. 273, An Act relating to public health and sanitation and authorizing the creation and maintenance of a joint board of health by agreement of the governing bodies of the cities and counties concerned. The November issue of the Journal carried an article pertaining to the possibilities of this measure. The bill to date has been amended by the Committee, passed by the House and is now in the Senate Committee on Public Health.

House Bill No. 305 (Committee on Public Health), An Act relating to social welfare, creating the office of state director of social welfare and, and prescribing his powers and duties, creating a state advisory council on social welfare, and prescribing its powers and duties, abolishing the state board of social welfare, amending sections of the General Statutes. This bill has passed the House and is on General Orders in the Senate.

House Bill No. 313 (Committee on State Affairs), An Act relating to certain cities of the second class, authorizing the issuance of bonds for the purpose of completing

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The use of cod liver oil and other fatty substances in the treatment of burns and superficial wounds has been well known to the profession for many years.

Now, another obvious development in the treatment of wounds of this type is the use of sulfathiazole compounded with cod liver oil ointment bases. This compound provides a maximum bacteriostatic action on both streptococcus and staphylococcus by stimulating epithelization and promoting granulation. *The use of sulfathiazole combined with this ointment base was found to be twice as effective as plain petrolatum, vanishing cream bases or soap bases.

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*Archives of Dermatology and Syphilology, Drs. E. A. Strakosch and V. M. Olsen, Univ. of Minn.



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or constructing an addition to a hospital, and for the equipment of such hospital or addition, and providing for the management, leasing, letting or renting of such hospital. This bill has passed both Houses and been signed by the Governor.

House Bill No. 324 (Committee on Public Health), An Act relating to social welfare, authorizing the state board of social welfare to designate certain hospitals and transfer patients thereto in certain instances; providing for the payment of the expense thereof; amending sections of the General Statutes of 1935. This bill has passed the House and is now in the Senate on General Orders.

House Bill No. 325 (Committee on Public Health), An Act relating to social welfare, providing for the admission of patients in the state sanatorium for tuberculosis, providing for treatment, examination, and certificate; providing for the determination of residence in Kansas; providing for cost of care, treatment, and maintenance by county social welfare boards and authorizing county social welfare boards to contract with applicants and other persons; amending and repealing certain sections of the General Statutes of 1935. The bill has passed the House and is at present on General Orders in the Senate.

House Bill No. 332 (Committee on Hygiene and Public Health), An Act relating to public health, providing prenatal serological tests for syphilis, and prescribing certain powers and duties and providing penalties for the violation thereof. This act is somewhat similar to House Bill No. 138 (still in Committee), but is more inclusive and describes the penalties for violation of the act. To date the bill has passed the House and is in the Senate Committee on Public Health.

House Bill No. 351 (Committee on Military Affairs), An Act relating to honorable discharged veterans of World War II and extending to such veterans certain rights, privileges and benefits now conferred by law on other veterans. The bill is on third reading in the House and the Committee has recommended its passage.

House Bill No. 355 (Committee on Hygiene and Public Health), An Act relating to public health (pertaining to municipality water supply for domestic purposes—requiring a written permit from the state board of health regarding such supply). The bill is in the House on General Orders in the Committee of the Whole.

Senate Bill No. 51, An act relating to public health, providing for suitable housing for, and authority for rental acquisition and use of real estate by, the state board of health. This bill was killed in the Senate Committee.

Senate Bill No. 52, An Act relating to public health, authorizing cooperation between the state board of health and federal agencies, and concerning the use of federal funds. The bill has passed the Senate and is on General Orders in the House with a recommendation of the Committee that it be passed.

Senate Bill No. 53, An Act relating to public health, requiring vaccination against smallpox and immunization against diphtheria for all school children under twelve years of age, providing for waivers for religious or other grounds, providing for records and reports and providing penalties for the violation thereof. The bill was killed in the Committee.

Senate Bill No. 82, An Act to define and to regulate the practice of dentistry and dental hygiene in the state of Kansas; to provide for unlawful acts; penalties; licenses and revocation, for a board of administration. The bill has passed the Senate and is in the House Committee on State Affairs.

Senate Bill No. 183, An Act relating to certain counties; authorizing the board of county commissioners to convert a girls' detention home into a hospital to be used for the care and treatment and control of contagious and infectious diseases, and authorizing the sale, rent or lease of such home to any city of the first class in such county for such purpose, and authorizing the board of county commissioners of such county to make a tax levy for the purpose of caring for delinquent girls. The bill has passed the Senate and is now in the House Committee on Public Welfare.

PHYSICIANS TOUR PLANT

Members of the Society in the southeast part of the state were the guests at the Kansas Ordnance Plant in Parsons on February 7. Dr. J. W. Spearing of the medical staff of the plant and the eight doctors, thirty-five nurses and five technicians employed at the plant.

More than one hundred doctors attending the meeting were taken through the hospital and later taken on a tour of inspection of the grounds in chartered buses. A brief program followed the dinner at which Dr. L. D. Johnson of Chanute, Councilor for the Third District, Dr. R. W. Urie of Parsons, Dr. E. C. Duncan of Fredonia, and Dr. C. S. Huffman of Columbus, gave brief talks.

GRADUATE NURSE SURVEY

The physicians of the nation are being urged to cooperate in a survey being made to locate all graduate registered nurses in the country, The Journal of the American Medical Association points out in its March 13 issue. The Journal says:

"The National Nursing Council for War Service, which represents the voluntary, professional nursing organizations in the total war program, urges every physician in the country to lend his help and support to the current nationwide effort to locate all graduate registered nurses. A second national inventory of nurses, a follow-up on the inventory of 1941, was begun in January 1943. To date (February 25) responses from nearly fifty per cent of the nurses in the country have been reported. To help bring in responses from the remaining fifty per cent, physicians are asked to:

"1. Encourage the nurses who may be associated with them, especially the nurses in their employ, to respond without delay to the postcard questionnaires sent to them by the special state agent of the United States Public Health Service in January of this year.

"2. Urge nurses they may know who have not received questionnaires (many physicians' wives who are nurses have failed to receive them) to request cards from the special agent in their states. If they do not know the agent's address, the National Nursing Council for War Service, 1790 Broadway, New York, will forward their requests.

"Information provided by the inventory will furnish the basis of operation for the nursing supply and distribution unit now being formed in the War Manpower Commission. The purpose of the unit, as the name implies, is to determine the availability of nurses for local, state and national emergencies and to aid in the equitable distribution of nurses, so that the nursing needs of the armed forces and of civilians will be adequately met. This distribution will be on a voluntary, not a compulsory, basis. The inventory is being conducted by the United States Public Health Service and has the approval of the National Nursing Council for War Service, the War Manpower Commission and the Health and Medical Committee, Office of Defense Health and Welfare Services, Federal Security Agency."

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JOURNAL DESK

Changes in addresses for mailing the Journal to members since the February issue have come to our attention and may be of interest to our readers, who like to keep up with the travels of our doctors:

Lt. Letteer Lewis from San Antonio, Texas to Lowry Field, Denver, Colorado.

Lt. Harry C. Wolohon from Scranton to Little Rock, Arkansas.

Lt. L. A. Donnell from Wichita to Palo Alto, California.

Lt. Clyde W. Miller from Wichita to Pineville, Louisiana.

Captain Edwin Enders formerly Lawrence, from Camp Bowie, Texas to an A.P.O. number in care of the Post Master, New York.

Dr. Kenneth L. Druet from Salina to the Army and Navy General Hospital at Hot Springs, Arkansas.

Dr. Stephen Ellis from Coffeyville to Springfield, Missouri.

Dr. G. R. Hastings from Lakin to Garden City, Kansas.

Dr. W. E. McKinley from Jewell to Osawatomie, Kansas.

Dr. R. E. A. Hines from Wichita to Fort Harrison, Montana.

Dr. A. H. Hinshaw from the University of Kansas Hospital to Station Hospital, Camp Hale, Colorado.

Dr. C. H. Johnson from Kinsley to Clearwater, Florida.

Major L. E. Knapp (Wichita) from Fort Jackson, South Carolina to an A.P.O., New York, New York.

Dr. Earl Martin from Oskaloosa to Natchez, Mississippi.

Lt. Comdr. H. F. O'Donnell formerly of Wichita from Mare Island California to an A.P.O., San Francisco, California.

Dr. J. W. Hanson of the Student Health Department of Kansas State College of Manhattan to Carleton College, Northfield, Minnesota.

Lt. Alza M. McDermott formerly of Ellis and located temporarily in California, is now on his second sea voyage according to word received from Mrs. McDermott. Places visited in the two and a half months voyage at sea are among the censored things in war time printing. He is senior medical officer of his ship.

Major Orville R. Clark formerly of Topeka and recently located in Atlanta, Georgia, has an A.P.O. address in New York.

GAS DEFENSE PROGRAM

The following bulletin has recently been received from the office of Civilian Defense of Washington, D. C., who have requested that it be made available.

"A program for civilian protection against gas is being developed as rapidly as possible through the Office of Civilian Defense. For the emergency medical service the duties are set forth as follows:

"Duties before gas attack: 1. Plan with assistance of Senior Gas Officer for the establishment of gas cleansing stations for cleansing gassed patients with other injuries and for cleansing of civilian protection personnel. Each hospital of 150 beds or more should be provided with a cleansing station. Cleansing stations should be available in the ratio of one per 50,000 population and should be located at smaller hospitals or casualty stations where 150-bed hospitals are not available in this ratio.

"2. Recruit, train, and assign personnel to gas cleansing stations for cleansing services.

"3. Provide instruction, in cooperation with Senior Gas Officer, for general public and civilian protection personnel in self-protection and self-cleansing (Operations Letter 46).

"4. Provide for instruction of physicians in diagnosis and treatment of chemical casualties.

"5. Assist hospitals in planning for handling of gas casualties.

"6. Assure adequate distribution of protective clothing and gas masks and other protective equipment to members of mobile medical teams and train personnel in their use.

"7. Make provision for training drivers of ambulances and sitting case cars in protection of their equipment against liquid-gas contamination; inform them of arrangements for vehicle decontamination by Emergency Public Works Service.

"8. Arrange for the protection from contamination of the equipment used to transport contaminated casualties insofar as it is possible."

OCD BLOOD PLASMA RESERVE

The Medical Division of the Office of Civilian Defense pointed out in a recent Medical Circular that plasma reserves are available in every Civilian Defense Region for use in the event of casualties resulting from enemy action or sabotage. The circular emphasizes that this plasma may be use for life-saving in any disaster. If the Office of Civilian Defense plasma is used in non-war related incidents, its use may be considered as a loan, and arrangements may be made later for its replacement, it is pointed out.

Through monthly reports issued by the blood plasma section of the Medical Division, Regional Medical Officers keep all chiefs of Emergency Medical Service, hospitals and American Red Cross Disaster Relief Chairmen informed concerning the amount and distribution of plasma reserves available in their states, and how localities may secure additional supplies in emergencies.

In cities where reserves are stored, they may be obtained by hospitals through the local Chiefs of Emergency Medical Service. If a community is without plasma or if its supplies are depleted, the local Chief of Emergency Medical Service may obtain additional plasma in emergencies from the State Chief of Emergency Medical Service.

LEGISLATIVE BILLS

A few of the bills that have passed in the 1943 session of the Kansas Legislature, which will be of special interest to the membership of the Society are printed in full for your information:

House Bill No. 121 (By Committee on State Affairs), An Act relating to the examination and registration of doctors of medicine or surgery and the state board of medical registration and examination, amending sections 65-1001 and 74-1001 of the General Statutes of 1935, and repealing said original section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. Section 65-1001 of the General Statutes of 1935 is hereby amended to read as follows: Sec. 65-1001. All persons intending to practice medicine or surgery after the passage of this act, and all persons who shall have not complied with section 65-1002 of the General Statutes of 1935, shall apply to said board at any regular meeting, or at any other time or place as may be designated by the board for a license. Application shall be made in writing and shall be accompanied by the fee hereinafter specified, together with the age and residence of the applicant, proof that he is of good moral character and satisfactory evidence



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In many patients, depression may occur as an accompaniment of some more fundamental pathology, either organic or psychogenic. In such cases, the physician should bear in mind that, while Benzedrine Sulfate will not affect the underlying condition, its stimulatory effects may help to alleviate the concomitant depression which so often interferes with the management of the case.

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that he has devoted not less than four periods of not less than six months each, to the study of medicine and surgery. All such applicants, except as hereinafter provided, shall submit to an examination of a character to test their qualifications as practitioners of medicine or surgery, and which shall embrace all those topics and subjects a knowledge of which is generally required by reputable medical colleges of the United States for the degree of doctor of medicine: *Provided,* That the examination in materia medica and therapeutics and in the theory and practice of medicine shall be conducted by those members only of the board who are of the same school of practice as the applicant claims to follow: *Provided further,* That graduates of legally chartered medical institutions of the United States or foreign countries in good standing, as determined by the board, or persons holding the certificate of the national board of medical examiners of the United States of America, may be, at the discretion of the board, granted a license without examination: *Provided further,* That the board may in its discretion accept, in lieu of examination or diploma the certificate of the board of registration and examination of any other state or territory of the United States or any foreign country whose standards or qualifications for practice are equivalent to those of this state. The board may refuse to grant a certificate to any person guilty of felony or gross immorality or addicted to the liquor or drug habit to such a degree as to render him unfit to practice medicine or surgery, and may, after notice and hearing, revoke the certificate for like cause, or for malpractice or unprofessional conduct.

Sec. 2. Section 74-1001 of the General Statutes of 1935 is hereby amended to read as follows: Sec. 74-1001. Within sixty days after the passage of this act, the governor, by and with the consent of the senate, shall appoint a state board of medical registration and examination, consisting of seven members, one to serve for one year, two for two years, two for three years, and two for four years, and the successors of each shall be appointed in the same manner for the term of four years, who shall be physicians in good standing in their profession, and who shall have received the degree of doctor of medicine from some reputable medical college or university not less than six years prior to their appointment; representation to be given to the different schools of practice as nearly as possible in proportion to their numerical strength in this state. Each member of the board shall take and subscribe the oath prescribed by law for state officers, which oath shall be filed with the secretary of state. The board shall organize by the selection of a president and secretary from among their own number, each to serve for such term as the board may designate, not exceeding four years. It shall have a common seal, and shall formulate rules to govern its actions. Its president and secretary shall have power to administer oaths pertaining to all matters related to the business of the board. The secretary shall be the custodian of the common seal and of the books and records of the board and he shall furnish to said board a satisfactory bond, conditioned for the faithful performance of his official duties. Said board shall hold regular meetings in June and in December, at such time and place as the board may designate in such of the chief cities of the state as the board may designate. Five members shall constitute a quorum for the transaction of all business; but no license to practice medicine and/or surgery shall be issued by the board upon less than five affirmative votes when the full board is present, or upon less than a majority affirmative vote when less than a full board is present. The board shall keep a record of all its proceedings, and also a register of all applicants for license to practice medicine in all of its branches within the state, together with a record showing the age of the applicant, time spent in the study of medicine, and the name and location of the institution or institutions from which the applicant may have received degrees or certificates of medical instruction; also, whether the applicant was licensed or rejected. Said books and register shall be prima facie evidence of all matters recorded therein.

Sec. 3. Sections 65-1001 and 74-1001 of the General Statutes of 1935 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the official state paper.

House Bill No. 324 (By Committee on Public Welfare), An Act relating to social welfare, authorizing the state board of social welfare to designate certain hospitals and transfer patients thereto in certain instances; providing for the payment of the expense thereof; amending section 76-1503 of the General Statutes of 1935, and repealing said original section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. Section 76-1503 of the General Statutes of 1935 is hereby amended to read as follows: Sec. 76-1503. The (board of administration) state board of social welfare shall have full charge of and power to manage, control and govern said sanatorium, subject only to the limitations contained in this act: *Provided,* That if the state board of social welfare shall be notified by the superintendent of the state sanatorium that the sanatorium is filled to capacity and there are persons on the waiting list of the institution who are in need of treatment for tuberculosis, it may designate any public or private hospital in the state of Kansas which will receive therein patients suffering from tuberculosis, and may transfer patients from the state sanatorium to such hospitals for treatment. All patients transferred to such hospitals shall remain under the control and supervision of the superintendent of the state sanatorium, who shall prescribe the type of treatment for such patients. The state board of social welfare is hereby authorized to contract with such public or private hospitals for the care of patients transferred thereto in such an amount as may be agreed upon for each patient per day and to pay such expense from the maintenance fund of the state sanatorium.

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Sec. 2. Section 76-1503 of the General Statutes of 1935 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

House Bill No. 332 (By Committee on Hygiene and Public Health), An Act relating to public health, providing prenatal serological tests for syphilis, and prescribing certain powers and duties and providing penalties for the violation thereof.

Be it enacted by the Legislature of the State of Kansas:

Section 1. Each physician or other person attending a pregnant woman in this state during gestation, shall, in the case of each woman so attended, take or cause to be taken a sample of blood of such woman within fourteen days after diagnosis of same is made, and submit such sample for standard serological tests for syphilis to either a private laboratory or to the public health laboratory of the state board of health at Topeka or to laboratories cooperating with the state board of health. The result of all laboratory tests shall be kept confidential and shall be reported on standard forms prescribed and furnished by the state board of health.

Sec. 2. In reporting every birth and stillbirth, physicians and others permitted to attend pregnancy cases and required to report births and stillbirths shall state on a separate sheet accompanying the birth certificate or stillbirth certificate, as the case may be, whether a blood test for syphilis has been made during such pregnancy upon a specimen of blood taken from the woman who bore the child for which a birth or stillbirth certificate is filed, and if made the date when such test was made, and if not made, the reason why such test was not made. Neither the fact that such a test was or was not made or was or was not required by law nor the result of any such test shall appear upon the birth certificate or be certified to any person for any purpose.

Sec. 3. Any person willfully violating any of the provisions of this act shall be deemed guilty of a misdemeanor, and upon conviction shall be fined in a sum not less than ten dollars nor more than one hundred dollars.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

COUNTY SOCIETIES

The Butler-Greenwood County Medical Society held a dinner meeting in ElDorado on February 12, at the Allen Memorial Hospital. Dr. W. E. Janes and Dr. Bertram Johnson of Eureka, discussed "Undulant Fever."

The Cherokee County Medical Society held a meeting in Baxter Springs on February 3, at which the following members were elected to office: Dr. W. J. Scott of Baxter Springs as President, Dr. W. H. Iliff of Baxter Springs as Secretary-Treasurer, Dr. J. H. Boswell of Baxter Springs as Vice-President. Dr. Boswell was also elected as Delegate.

The Ford County Medical Society entertained with a dinner meeting in Dodge City on February 12. The wives of the members were dinner guests. Dr. Frank E. Coffey of Hays was the speaker.

The Labette County Medical Society elected the following new officers at a dinner meeting held in Parsons re-

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cently: Dr. T. D. Blasdel of Parsons as President, Dr. M. C. Ruble of Parsons as Vice-President, Dr. O. E. Stevenson of Parsons as Secretary-Treasurer. The new officers will assume their duties at the February 24 meeting. Guests of the organization were the medical staff of the Kansas Ordnance plant.

The Linn County Medical Society held election of the following new officers at a meeting held in Mound City on January 29: Dr. J. T. Kennedy of Blue Mound was re-elected President, Dr. H. L. Clarke of La Cygne was re-elected Secretary-Treasurer.

The Marshall County Medical Society at its meeting in Marysville held recently elected the following to office: Dr. O. G. Hutchinson of Marysville as President, Dr. O. P. Wood of Marysville as Vice-President, Dr. Henry Haerle of Marysville as Secretary-Treasurer and Dr. M. A. Brawley of Frankfort as Delegate.

The Mitchell County Medical Society held a regular meeting on March 2, in Beloit. Dr. John Kleinheksel of Wichita, spoke on "Diabetes."

The Montgomery County Medical Society met in Independence on February 18.

The Pratt County Medical Society held a dinner meeting at Pratt on January 22.

The Wyandotte County Medical Society held a meeting on February 16, in Kansas City. The scientific program consisted of a talk on "Blood Transfusion—Its Technque and Dangers," by Dr. Clarence J. Weber of Kansas City, and a movie on "Nicotinic Acid Deficiency," by courtesy of the Eli Lilly Company. Dr. Ward Summerville and Dr. Fred Angle of Kansas City, discussed Dr. Webers' paper.

DEATH NOTICES

Dr. Shirley Francis Boyce, 47 year of age, of Hugoton, died on February 17, after a ten day illness in Wichita. Dr. Boyce was graduated from the Kansas City University of Medicine and Surgery in 1916. He was a member of the Meade-Seward County Medical Society.

Dr. William Henry Carter, 65 years of age, died on February 13, at Wichita. He was graduated from the Kansas City Medical College in 1904. He was a member of the Sedgwick County Medical Society.

Dr. David W. Collins of Effingham, died on March 14, 1942. Dr. Collins was graduated from the Kansas City Medical College in 1898, and at the time of his death was an active member of the Atchison County Medical Society.

Dr. Oscar M. Longenecker, 76 years of age, died on February 26, at his home in Kansas City. He was born in Woodbury, Bedford County, Pennsylvania, on October 20, 1866. Dr. Longenecker was graduated from the Kansas City Medical College in 1899, and practiced first in Rosedale. He was a member of the Wyandotte County Medical Society.

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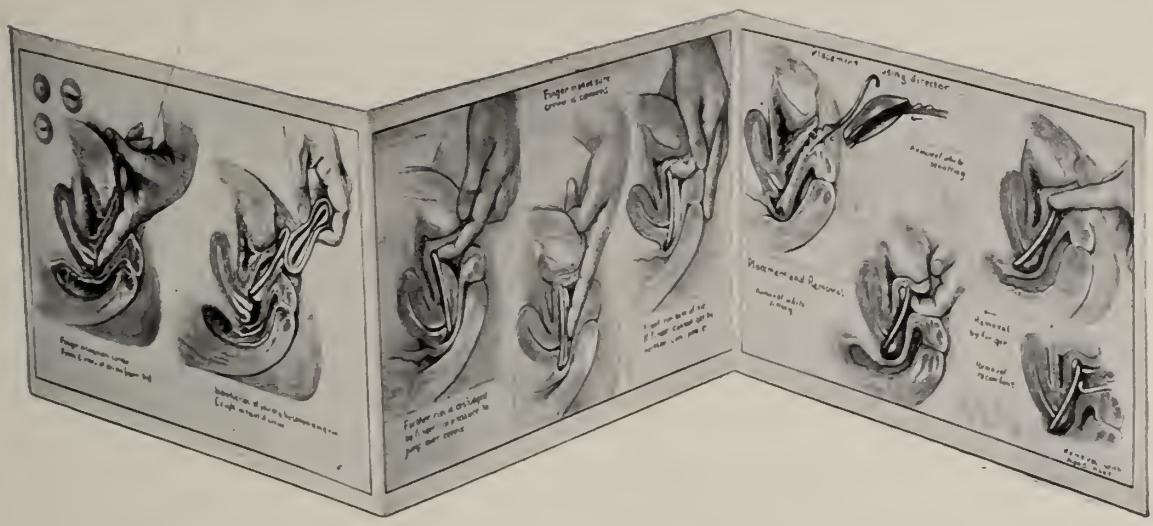
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Dr. J. Carroll Montgomery, 68 years of age, died on February 2, at his home in Topeka. Dr. Montgomery was graduated from the College of Physicians and Surgeons of Kansas City in 1901. He has practiced at Manhattan, Topeka and Wichita, and was director of the Child Hygiene Department of the Kansas State Board of Health, and later director of the Wichita Health Department.

Dr. Charles C. Stillman, 70 years of age, died on January 28, at his home in Morganville. He was born in Riley County on June 30, 1872, and was graduated from the Kansas Medical College of Topeka in 1897. He was an honorary member of the Clay County Medical Society of which he had served as President for many years, was a former Councilor of the Society and a member of the Defense Board.

MEMBERS

Word has been received that Dr. Everett E. Murray will practice with Dr. C. D. Snyder and Dr. H. H. Jones of Winfield. Dr. Murray has recently returned from Shantung, China, where he was a medical missionary and surgeon in charge of the Presbyterian Hospital. He returned to the United States on an exchange steamer with many other Americans who had been interned by the Japanese.

Dr. I. J. Waxse, formerly of Altamont, has recently purchased a hospital at Oswego.

Dr. L. D. Mabie and Dr. Charles M. Stemen of Kansas City, have recently been named as county health officer and county physician, respectively, for Wyandotte County.

Dr. F. I. Stuart of Atchison, has recently been named as county physician for Atchison County to succeed Dr. C. L. Ramsey also of Atchison, who has resigned to accept a position on the staff of the Santa Fe Hospital at Topeka. Dr. Ramsey was located for a time at Effingham.

Word has been received that Dr. D. R. Wilson of Mound Valley, has been commissioned as a Major in the United States Army and reported for duty in February. Dr. Wilson also served in the first World War.

The article entitled "Retrobulbar Neuritis," by Dr. Louis R. Haas of Pittsburg, which was published in the June issue of the Journal, was abstracted in recent issues of The Medical World, The Journal of Nervous and Mental Diseases and in the Yearbook of Eye, Ear, Nose and Throat.

Major Omer M. Raines, formerly of Topeka, has recently completed a course in surgery of the extremities in Chicago, and has returned to his assignment in Denver.

In 1936 the death rate from pneumonia in the United States was 93.0 per 100,000 population while in 1940 it was 53.8, according to the United States Public Health Reports. Comparable figures for Ohio were 84.6 in 1936 and 55.5 in 1940.—Ohio State Medical Journal.

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BOOK NOOK

BOOKS RECEIVED

THE 1942 YEAR BOOK OF GENERAL THERAPEUTICS—Edited by Oscar W. Bethea, Ph.M., M.D., F.A.C.P., Professor of Clinical Medicine of Tulane University School of Medicine; Senior in Medicine of the Southern Baptist Hospital; Senior Visiting Physician of the Charity Hospital; member of the Revision Committee of the United States Pharmacopeia for 1930-1940; author of "Clinical Medicine" and "Materia Medica, Drug Administration and Prescription Writing." Published by The Year Book Publishers, Inc., in 1943. The price of the book is $3.00.

THE PRINCIPLES AND PRACTICE OF WAR SURGERY, With Reference to the Biological Method of the Treatment of War Wounds and Fractures—J. Trueta, M.D., formerly Director of Surgery of the General Hospital of Catalonia, University of Barcelona; Assistant Surgeon (E.M.S.) Wingfield-Morris Orthopaedic Hospital of Oxford; Acting Surgeon-in-Charge of Accident Service of Radcliff Infirmary of Oxford, with an introduction by Owen H. Wangensteen, M.D., of Minneapolis, Minnesota. Published by the C. V. Mosby Company of St. Louis, Missouri, the book is priced at $6.50.

ANNOUNCEMENTS

The International College of Surgeons will hold their Fourth Assembly on June 14-16 at the Waldorf Astoria Hotel in New York City. The program will be devoted to war surgery and rehabilitation.

According to word received from Dr. Miley B. Wesson, Chairman on Research for the American Urological Association, the annual meeting of that organization scheduled for June in St. Louis, Missouri, has been cancelled. He has also requested that we announce the cancellation of the $500 Research Prize which is awarded annually by that organization.

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KANSAS MEDICAL ASSISTANTS SOCIETY STATE MEETING

The State Board of the Medical Assistant's Society at their last session, decided that the next annual meeting of the organization will be held on Sunday, May 16.

In spite of taxes, priorities, rationing, difficulty of transportation, and such, it is believed there will be a good attendance. Registration will commence at 9:00 a. m. Since the hotels are struggling under the same rationing rules as are individuals, it will be necessary that we know as early as possible if you are planning to come. Watch the April issue of the Journal for further announcements.

Grace Brooks, Registration Chairman, care of Dr. J. A. Crabb, 630 Kansas Ave., Topeka, will contact your local society soon. However, information may be secured by writing to her direct.

MEDICAL ASSISTANTS NEWS

The Cowley County Medical Assistants held its annual dinner in Arkansas City on January 28, at the country club. The guests of the organization were the medical staff at Strother Air Field and their wives. By courtesy of the American Hospital Supply Company a movie on "Blood Plasma" was shown.

The Shawnee County Medical Assistants Society held its February 1 meeting at the Pennant Cafeteria. Mrs. Florence Linton, President of the State organization discussed "First Aid." At the March 1 meeting, Dr. D. D. Carr of the Kansas State Board of Health spoke on "Public Health." The organization is making plans for the annual meeting to be held on May 16, in Topeka.

Tuberculosis' annual death toll in India is approximately 1,000,000 lives—Bulletin, National Tuberculosis Association.

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FOR SALE—Entire office equipment, including instruments and files, of Eye Ear, Nose and Throat Specialist. Collections last year over $10,000. Growing towo of 20,000. Write Journal of The Kansas Medical Society C-0-4.

FOR SALE OR RENT—Equipped office, four-room building, for general practice in towo of 1,400, south-central Kansas, for sale or rent. Write for details to T. J. Thomas, M.D., Veteraos Administratioo Hospital, Waco, Texas.

FOR SALE—Entire ultra-modern medical equipment of the late Dr. Harrison B. Talbot for sale—Address Journal of The Kansas Medical Society, C-03. Mrs. H. B. Talbot, 600 West Eleventh Street, Apt. No. 6, Topeka, Kansas.

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

AUXILIARY

PRESIDENT'S MESSAGE

I have just returned from a visit to the auxiliaries in the southern part of Kansas and feel heartened and encouraged by the continued interest in auxiliary work shown by these units. It is not without some sacrifice that we continue our normal routine in addition to the many demands made on us.

As you no doubt know, March 30 has been set aside as Doctor's Day. Here are some suggestions you may wish to follow in your community in observance of this day:

1. Publish a tribute to our doctors in your local newspaper.
2. If broadcasting station is available have auxiliary sponsor Doctor's Day program.
3. Send telegrams, letters, notes, or telephone each doctor in your county best wishes.
4. Send flowers to doctor's offices, hospitals or clinics.
5. Send buttonniere to each doctor to wear as reminder of our love, respect and appreciation of him.
6. Place flowers on graves of deceased doctors in your local cemetery.
7. Visit the sick and retired physicians, or remember them with flowers or notes.
8. Plan social function for your medical society—barbecue, luncheon, dinner, dance or picnic.
9. Plant trees in honor of your medical society.
10. Devote day of March 30 to your Doctor and our Doctors.

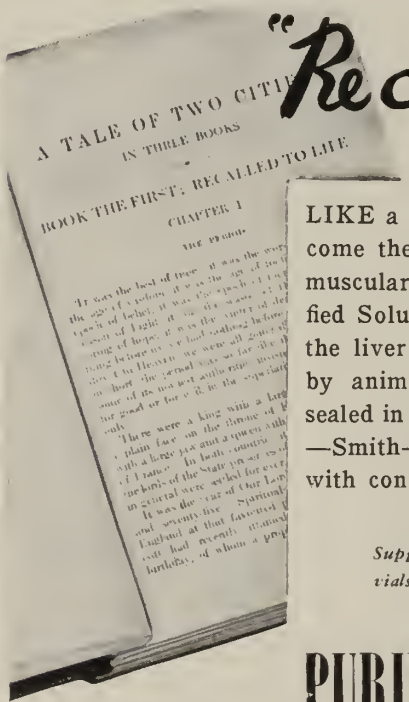
I hope that most of our units can observe one or more of these suggestions.

Sincerely,
MRS. C. OMER WEST.

Surgery in 1791—Many physicians served during the Revolutionary War and obtained their surgical experience in this manner. Asepsis and anesthesia were, of course, unknown, and the closed cavities of the body—the chest, abdomen, brain and joints—were forbidden ground except in cases of accident or injury. Amputations, reduction of fractures, removal of external growths, lithotomy and cataract extraction were the principal surgical procedures.

Dr. Philip Carrigan, a Concord physician, amputated a leg following an accident. Finding his saw too dull, he sent to a neighboring house to borrow a sharper instrument with which to complete his operation. The end of the bone was evidently left bare, for he picked it with an awl and applied New England rum to promote healing. On another occasion, he amputated a finger with a mallet and chisel. Many of the major surgical operations at a somewhat later date were performed by "country doctors" —for example, the ligation of the common carotid artery by Dr. Amos Twitchell of Keene.—Henry H. Amsden, M.D., New England Journal of Medicine.

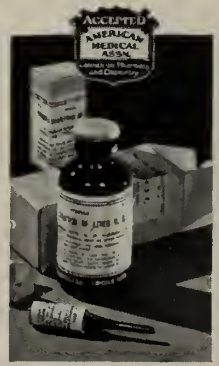
A break in the chain of medical teaching in any country spells disaster for the next generation.—Raymond B. Fosdick, in the Rockerfeller Foundation Review.



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FUNDAMENTALS OF PSYCHIATRY VII

THE OEDIPUS AND CASTRATION CONFLICTS

William C. Menninger, M. D.

Topeka, Kansas

During the first three or four years of the child's life, namely, during the period when he is passing through the "oral" and "anal" phases of "psychosexual development," there are no essential differences between this development in the little boy and the little girl. During these earliest years one can assume that the child is in a sense bisexual, that is, that all children are both masculine and feminine, or one might say that they are neither masculine nor feminine exclusively. Judged either on the basis of the methods they use to obtain gratification or on any observable behavior, one can determine no differentiation between the sexes. On the other hand, at the "genital" level, namely, at the age of four or five, the interest and attention focused upon the genital organs, brings to the front, even in the child's mind, the difference between the sexes. This difference gives rise to two major problems which every child meets; the Oedipus situation and the castration fears. There are some minor differences, between the sexes in their reactions to these problems. We shall consider first the little boy's development and then point out the differences in the girl's reactions.

THE OEDIPUS SITUATION*

The first of the problems, known as the Oedipus situation or complex, arises during the period of the life of the little boy when his attention has become focused on his genital organs. Simultaneous with this stage of development his interest in and attachment to the mother increases greatly and she becomes his special object of love. Along with this attachment to the mother the little boy with his childish mind recognizes that the father has certain privileges, receives certain attentions and affections from the mother which he is not permitted to have. As a consequence, the father is something of a rival, and as a result of this rivalry the child develops resentment and jealousy toward the father.

In the child's life then the conflict arises as to how he may have his mother as his love object, and at the same time, establish some satisfactory relationship to his father. It is apparent that this striving for the mother cannot be interpreted or even thought of in terms of adult sexual love. At most it is infantile in nature; it is merely a striving rather than any formulated definite aim. The child is not conscious of his objective and we recognize its presence by observation of his speech and behavior. One can see many expressions and evidences of this conflict. The boy is usually far more intimate with his mother in physical caresses than with his father. The child gives many evidences of a desire to be caressed and have bodily contact with the mother, to be rocked, to be held, to be petted. It is a very common experience to hear the little child express verbally his undisguised wish that he might sleep with mother, that he didn't care if daddy didn't come home, or that he wishes mother would love him like she does daddy. Through psychoanalysis we have discovered the widespread existence of frank desires on the part of the child to have sexual relations with the mother. Many patients relate very definite memories of having wished that they might have had sexual relations with the mother, that she might have "taught them how," that she might have shared herself with them.

The immediate result of this intense attachment to the mother is a vague fear of the father, sometimes a very real fear, and in addition, the child feels resentment and often jealousy toward the parent of the opposite sex. This whole conflict for the child arises at the time of his life when he has become interested in his genital organs, and as a consequence there is usually an excitation, frankly sexual in its nature, which increases and intensifies the interest in the genitals. As a result of this excitation the majority of children at this period manipulate or play with their genitals in one way or another, a process termed masturbation.

THE CASTRATION ANXIETY COMPLEX

As a result of this infantile masturbation the child often is punished. Far too often the parent discovers the child playing with his genitals and makes the situation much worse by administering some kind of spanking or corporal punishment. Far too often the parent may tell the child or by his manner indicate some kind of threat or injury to the genitals. It is easy for the child to interpret this threat of deprivation in view of the fact that when a toy is forbidden and he persists in playing with it the parents usually take it away from him. Consequently, the child develops the fear that the parent might take his genitals away from him. This fear is greatly accentuated by the fear of the father because of the child's desires for the mother, and his belief that the father might punish him on this score. The child's desires for the mother conflict with the fact that he cannot have her and his disappointment is blamed on the father, even though the father is not responsible. Because the child cannot justify his hostility for the father he feels guilty and because of his guilt he fears punishment in some form. Because the conflict involves his sexual desires and hence the genital organs, it may be presumed that the child fears that the punishment will be directed toward this part of himself.

This fear of injury to his genitals, either because of the threats made against him on account of his masturbation or because of the guilt about his hate for his father, is often not taken seriously by the child until he discovers that girls apparently do not have any genitals. This is interpreted by the little boy to be the result of castration. In such instances the child may develop a great deal of anxiety, centering about this conflict, which is technically termed "castration anxiety."

SOLUTION OF THE OEDIPUS SITUATION

Every child must solve the Oedipus problem, as well as his castration anxiety, if he is to mature in his "psychosexual" development. The normal solution results usually because the fear of castration becomes so threatening that it literally breaks up the attachment to the mother. This comes about when the little boy decides to be like his father, to identify himself with his father, and through the strength from such an identification stamps out the sexual interest in his mother and the desire for her. Through this identification with the father and making himself like his father, the little boy begins the creation of his own conscience. He builds up prohibitions which prevent him from giving further consideration to his own desires to have his mother as a love object and to his resentment and hate for his father. Thus the fear of castration instead of coming from some outside source, i.e., as the result of some punishment from his father, now comes as the dictate from an internal source, i.e., from a part of his own personality that serves as a kind of personal policeman which imposes restraints upon himself. The eventual solution results when he finds a substitute for his mother in the form of a girl friend and later a wife.

In many instances the Oedipus situation is never solved in a satisfactory manner. This occurs when there is an excessive fear of the father and also when there is excessive resentment. Resentment or hate is followed by a feeling of guilt, and when the child develops an extreme sense of guilt he is unable to identify himself with his father. As a consequence, he gives up trying to be like father and patterns himself after his mother, thus making himself feminine instead of masculine. Through this procedure he develops into a feminine type of man, and remains passive not only to his father, but to all men. It is such a solution of the Oedipus situation which may lead eventually to interest only in men and in a perverted method of sexual gratification called homosexuality. It is often the cause of mental ill health in later life in the form of neuroses or even psychoses. In the same manner, a girl who fails to give up her attachment to her father and her jealousy of her mother, solves the conflict by identifying herself with her father and becomes a masculine type of woman. Women with strong masculine strivings do not get along with feminine women and because they deny their femininity they do not get along with men (except feminine passive men).

The effects of an unfortunate solution of the Oedipus situation are far reaching. Not only is this the origin of masculine women and feminine men but also of many other abnormal relationships in adult life. The unsatisfactory solution of the Oedipus complex explains the very frequent life long attachment of a daughter to a father or a son to a mother. This situation often appears to be the same type of love relationship existing between mates and is conspicuous to everyone except the persons involved. The unsolved Oedipus complex explains situations in which we find a very masculine aggressive woman married to a spineless, weak little feminine man. It explains unusual characters: women who permit themselves to be dominated by a masculine type of woman and men who glory in their devotion to a severe, dominating father substitute. As has been mentioned, this conflict is usually the basis for finding gratification of the sexual desires with individuals of the same sex.

FEMALE DEVELOPMENT

The development as outlined above applies more specifically to the male. In some details, the de-

velopment of the little girl differs from that of the boy. In both instances, the first attachment is to the mother. In the case of the boy we have seen that this attachment continues; in the case of the girl there is a shift from an interest in the mother to an interest in the father with resentment toward the mother as a rival. This resentment is increased because the mother is blamed in some way for a lack of the external genitals given a boy, i.e., the absence of a penis.

The problem, however, of accepting a feminine role in life is a much more difficult one than accepting the masculine role. We must assume that the little child, either boy or girl, does not want to be a passive, dependent individual, as normal adult femininity demands. The girl is faced with the fact that she is born into what is primarily a man's world, where most of the work is done by men, where the major discovering, exploring, scientific work, and business is all carried out by men. Furthermore, the little girl whether she wishes or not has to accept the role of being a member of the "weaker" sex, because of man's superior physical strength. In addition, the woman has the "burden" of menstruation. Even in intercourse she takes the passive role underneath the man.

Civilization through various cultural and social influences has forced woman to a passive role. For many centuries she was practically the slave of man. Only since 1920 has she had suffrage, and even today there is a widespread antagonism against women taking part in politics. There is no better example of the inferior role into which women were forced than that shown in the field of nursing, where she not only was not wanted but actually was not permitted until seventy-five years ago. The development of femininity is complicated by many factors other than those which exist within the child herself during her very early years. Every woman who becomes "feminine" has to be "broken in" to being a woman.

The normal solution of this early conflict does not always result in the ideal, masculine man and the ideal, feminine woman. In fact, probably the majority of people show certain traits of the other sex, many of which are not at all recognized by the individual himself. Undoubtedly the solution of the problem is a much more difficult one for the little girl than it is for the little boy, and the result is that there are probably many more "masculine" women than there are "feminine" men. This is further attested to by the fact that a great percentage of women at some time in their lives envy the position of men; the little girl wants to be a boy much more often than the little boy wants to be a girl. The result in either case, if the wish is very deeply set, is the development of character traits of the opposite sex, with the man making himself unintentionally somewhat feminine, and the woman making herself unintentionally somewhat masculine.

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* Footnote: The term "Oedipus complex" is taken from the Greek myth. Oedipus, the son of Laius and Jocasta, was left to die on a mountain side because his father had been warned that his own son would kill him. Oedipus, however, was saved and adopted by the King of Corinth. He later learned also from an oracle that he would slay his own father, but believing that the King of Corinth was his father left the country. By chance, however, he met his father whom he did not recognize and in the course of a quarrel killed him. In his travels he came to a country which was plagued by a monster, the Sphinx, which asked riddles of all travelers and a failure to solve the riddle resulted in death. Oedipus solved the riddle and as a reward was given the hand of the Queen of the land. This Queen turned out to be his mother who bore him two sons, twins, and two daughters.

THE DOCTOR OF MEDICINE AND HIS RESPONSIBILITY*

Alfred W. Adson, M. D.

Rochester, Minnesota

Members of the North Central Medical Conference, representing the states of North Dakota, South Dakota, Minnesota, Wisconsin, Nebraska, and Iowa, have entrusted me with the responsibility of addressing this National Conference on Medical Service concerning medical problems that are of both local and national interest.

It is the duty of every doctor of medicine to prevent illness, to supply adequate medical care to those who are ill, to perpetuate the science of medicine and to encourage medical investigation. It is true that the average physician would prefer to go unregimented among his sick and administer to their needs, irrespective of race, color, creed, or financial status, rather than busy himself with administrative and political problems. However, since the courts have ruled that group health is a business and have found that medical societies are guilty of restraining trade when attempting to maintain the standards of the practice of medicine, a challenge has been issued to

* Presented at the meeting of the National Conference on Medical Service, in Chicago, Illinois, on February 14, 1943, reprinted by permission of the author.

the medical profession: Is there a necessity for lay groups and the Federal Government to take over the control of the practice of medicine.

Has the science of medicine reached its zenith? Have the men and women of medicine become so decadent that they are unable to assume their responsibilities? Are the doctors of medicine no longer able to conduct their practice without government control? Do they lack ability to appreciate their problems? Or are they incapable of constructive leadership in the solution of the numerous responsibilities that are confronting the medical profession today? The reply is, "No."

The science of medicine has been nurtured by men and women who have advanced the knowledge of relieving pain, correcting deformities, lowering infant mortality, prolonging life and preventing illness by sanitary and public health measures. This progress must continue if civilization is to survive.

The medical profession is conscious of social and economic changes and stands ready to co-operate with, and offer leadership to, state and federal agencies in the solution of medical problems. It further believes that better medical service can be rendered by offering advice and leadership to welfare agencies than by serving as a tool under political bureaus.

The medical profession recognizes the necessity of state and federal control of communicable diseases and medical services to inmates of state and federal institutions. It appreciates its responsibility to the Armed Forces and expects to supply the needed personnel. It is willing to co-operate with welfare agencies in providing adequate medical care for the low income and indigent groups of the population; but in providing this care, it believe that the medical service is augmented when the patient-physician relationship can be maintained by permitting the patient, whenever possible, to choose his own physician. In order to protect the public from worthless, so-called medical procedures and unnecessary operations by unscrupulous individuals, it likewise believes that high standards of medical education and practice must be maintained. This applies not only to the practice of medicine in the office; it applies to the practice of medicine in the humble home or in the most modern hospital.

Although medical education begins in the medical school, it is never completed as long as the physician continues his practice. Medical schools have adopted standards of education and have required certain courses of study in order that the public might avail itself of the best practices of medicine. Medical licensing boards have further protected the public by requiring of their candidates for licensure prescribed courses of study. State laws governing the practice of medicine and conduct of physicians further protect the public from irregular practices and charlatans.

Medical societies, county, state, and national, have been organized to further the education of the physician by acquainting him with the advances and new discoveries in the science of medicine. They likewise serve as administrative units in the consideration and solution of medical problems. It is obvious that the responsibilities of the respective state organizations are greater than those of the county organizations, and that the national organization is charged with greater responsibilities than those of the state organizations. However, it is also obvious that the activities of all groups must be integrated if medical problems are to be solved effectively. In some states, such as Minnesota, the administrative and the legislative bodies have the confidence of the medical profession. Likewise the medical profession has the confidence of the state administrative and legislative bodies. This confidence has made it possible for representatives of both groups to attack and solve the medical problems which are of mutual interest.

The national organization, through its respective bodies and committees, has conducted an excellent program in furthering medical education. It has crystallized the standards of medical education for the medical student as well as for the practitioner of medicine; it has investigated the claims of new and nonofficial remedies, foods and therapeutic measures and has further protected the public by approval or disapproval of the articles investigated. It has taken active steps through its Procurement and Assignment Committee in providing medical men for the Armed Forces without robbing communities of adequate medical personnel and has made provisions for relocation of physicians where more medical service is needed. It has acquainted the public with the important role that the science of medicine plays in their daily lives, but apparently it has not gained the confidence of the national administrative and legislative bodies that some of the state medical societies have attained. The National Physicians' Committee has made some progress in acquainting the public with the necessity of medical science, but it too had not obtained the confidence of the national administrative and legislative branches of our Government. Therefore, the recent court decision has emphasized the weakness of conducting a program of education to acquaint the public, the administrative and legislative bodies of certain states, and the national institutions with the important function of the

science of medicine in our civilization. It is our duty, as physicians and citizens, to assure those in administrative positions and legislative bodies that we are familiar with the social and economic changes that have thrown greater responsibilities on the medical profession and that we stand ready to co-operate with these agencies in offering leadership in the solution of the numerous problems which nonmedical personnel are trying to solve.

The chief medical problem that concerns doctors of medicine and welfare agencies is that of providing adequate medical care to those who are financially unable to procure this care. This group includes those who are indigent and those with low incomes. Medical care, in its true sense, embraces more than emergency treatment for a particular illness, since it should include a rehabilitation program, such as the correction of deformities and ailments that impair the efficiency of individuals. The rehabilitation program also should include adequate and proper diets, physical training, recreation, protective clothing and housing. In most of the cities the indigent are provided with proper medical care through the charity hospitals, where competent physicians give of their services. This same group in the rural districts is not always so fortunate, since local welfare boards are reluctant to provide this care. It is in these situations that the physicians have been overburdened in assuming all of the responsibilities in providing the necessary medical care. Prior to the more recent economic changes, physicians were willing to assume this obligation because those who could afford to pay for professional services attempted to meet their obligations. However, as a result of the recent social and economic changes, the Government has taken over more and more control of the civilian's activities, and those with moderate and low incomes have been less willing to assume their obligations of medical care and are insisting that it is the Government's duty to provide medical care and that it is the individual's privilege to squander his extra change.

The problems of this group cannot be solved by physicians alone or by federal, state, and local welfare agencies alone. Ours is a joint responsibility. Conscientious leadership by physicians working in co-operation with county, state and federal agencies can and will bring forth a solution of the problem. Medical services must be rendered, and the physician is willing to give a good portion of his services. But the Government must provide reasonable funds for the care of its indigent, as it must provide for catastrophic illness in the low income group. Nevertheless, those who come within the low income group should likewise be made to realize that they too owe a responsibility to their local, state and federal governments and should be encouraged and advised in budgeting their income and expense.

Industrial compensation has accomplished much in providing proper medical care and the necessities of life, during illness, for those employed in industrial institutions. However, there still remain a large group of individuals who receive moderate or low incomes and are desirous of securing the assurance of adequate medical service in the event of illness. Insurances companies have offered this protection through policies covering accident and illness disabilities, but again this protection only partially solves the problem, since many an insuree expects more for his premium than the insurer is able to give. In several states medical societies have attempted to develop medical service plans whereby the insuree may purchase from the doctors within the group full medical protection or medical protection for unexpected, serious illnesses. In some states under the farm security program, experimental medical service plans are being tested out by use in an attempt to find the solution of the problem of supplying medical care to the farmers and their families who are being rehabiliated. In some instances physicians are hired to render medical service to indigent and co-operative groups. Even though physicians, welfare agencies and low income groups are struggling with the problems of medical service plans, as yet a satisfactory plan for all classes has not been developed. The recipients expect more than the vendors can supply for the premiums paid.

These controversies give rise to discussions on the necessity of compulsory medical insurance. Should such a program evolve, results would be disappointing from the patient's as well as the physician's points of view if placed under the control of political bureaus, and the patient would be deprived of his free choice of physician.

Therefore, we as physicians believe that a more equitable solution of the perplexing medical problems referred to will be reached if we are permitted to consult and advise administrative officials, legislative bodies, and welfare agencies, since we are more familiar with the medical needs of our respective communities than are those who have a casual knowledge of the medical necessities.

It is befitting to quote the statement found in the opinion written by Justice Miller, of the United States Court of Appeals, of the District of Columbia, in the case of the United States of America versus the American Medical Association, and the case of the United States of America versus the Medical Society of the District of Columbia. The statement in brackets is mine.

"It may be regrettable that Congress chose to take over in the Sherman Act the common law concept of trade, at least to the extent of including therein the practice of medicine. Developments which have taken place during recent decades in the building up of standards of professional education and licensure, together with self-imposed standards of discipline and professional ethics, have, in the belief of many persons, resulted in substantial differences between professional practices and the generally accepted methods of trade and business. As we pointed out in our earlier decision, the American Medical Association and other local medical associations have undoubtedly made a profound contribution to this development. (However, our task is not to legislate or declare policy in such matters, but rather, to interpret and apply standards and policies which have been declared by the legislature. That Congress did use the common law test there is no doubt. That Congress was not othewise advised was perhaps because of the failure of the professional groups to insist upon the distinction and to secure its legislative recognition.)"

Does the medical profession of this country need a stronger invitation, or a more direct challenge to take an intelligent, helpful and fair stand in the enactment of legislation that not only concerns the public welfare but the welfare of medicine itself? Does not the medical profession of this country, as citizens and tax payers, have a right to express its opinion in these matters before legislation is enacted and rules and regulations adopted by some bureau? I do not share the opinion that the time for the medical profession to speak up is after such things have taken place. Neither do I have the opinion that Congress would be resentful of intelligent, courageous and fair advice on such matters. What better proof can be asked than the quotation from Justice Miller's opinion that the Court is not responsible for the absence of advice from the medical profession when Congress is drafting a law.

It is not the purpose of this paper to criticize the efforts of our national medical organization nor to criticize the efforts of the National Physicians' Committee, but it is the desire of the members of the North Central Medical Conference to express a wish that a more active program be conducted to acquaint the public, government officials, and legislative bodies with the necessity of medical science and the important role it plays in our civilization. It is essential that we as physicians dispel the fear that government administrative agencies and legislative bodies have of our medical organizations and that they be assured of our co-operation in solving the social and economic problems that confront us as a nation.

The functions of acquainting the public on matters of medical interest, assisting bureaus in formulating plans on medical care and offering constructive advice on proposed medical legislation rightfully belong to the national organization known as the American Medical Association. They could be assigned to the National Physicians' Committee, or they might even be undertaken by unifying the activities of the various state committees on public policy and legislation. Representative committees could be appointed for each of the component societies, county, state, and national. These could all be so integrated that national opinion and advice could be obtained and made available for committee hearings on legislation within a few hours' time. Through the national, state, and county committees the entire profession could be informed of proposed medical legislation. Thus, the local constituents of the respective state and federal legislators could express their views before legislation is enacted. Some states already have medical advisory committees from each county. They also have state medical committees on public policy with a physician as part-time executive chairman assisted by legal counsel. A national committee constructed on the same plan as these state committees would have to be created. A physician who has practiced medicine should be chosen as the executive chairman. Both he and his legal counsel would need to be stationed in our national capital. The expense of the national committee on public policy could be financed by one of three agencies, the American Medical Association, the National Physicians' Committee, or the respective state organizations bearing the expense jointly. It would appear more equitable if each physician would be assessed each year for the specific purpose of maintaining a national committee on public policy and legislation.

Our problems are not unlike those of dentists and hospital associations. Therefore, unified effort of medical, dental and hospital associations should further the welfare of the patient.

According to the British correspondent of the Journal of the American Medical Association, women medical and dental officers in the Women's Auxiliary Air Force are now authorized under a new order from the Air Ministry to attend men as well as women. The order also grants women equal rights in seniority and rank as professional men in the air force, thus for the first time affording women the opportunity of becoming station senior medical officers. Until now a distinction has been made between the duties of men and of women holding similar appointments.—Connecticut State Medical Journal.

President's Page

As another Society year draws to a close, the medical profession in Kansas, as well as elsewhere in this country, finds itself in the midst of many problems. As in all other fields of human endeavor, the war has modified our activities and has increased our problems and we all face the fact that the repercussions of the war and social change may affect medical practice in many ways. Change is inevitable in all things but we hope that the changes involving medicine will be in the direction of progress and improvement.

Medicine today is in the center of a stream of strong and diverse currents tending to force it in this or that direction. It is reasonable to expect the charting of a sound course only if the medical profession itself has an adequate voice in such charting. Every physician must put his shoulder to the wheel in planning and achieving progressive medical policies.

Medicine has yet much to accomplish in attaining better public and legislative relations that will give us more influence in the direction of medical policies. We have much to attain along this line in Kansas.

In closing, I wish to express my appreciation to the members of The Kansas Medical Society for the honor of being your President during the past year, and to all members, officers and committees, my thanks for your splendid cooperation in our Society work. The Kansas Medical Society, under the excellent leadership of our incoming president, Dr. John Lattimore, will ably meet its problems during the ensuing year.

Sincerely,

Henry N. Ickes, M. D.

EIGHTY-FOURTH ANNUAL MEETING

The war time activities of physicians, curtailment of transportation, shortage of hotel facilities, and rationing have all contribuated to the decision of the Council to hold a business meeting rather than the usual scientific session of the Society. It is believed that a meeting of this kind is the best possible one at this time, although the Society committees are making plans for some additional district scientific meetings at a later date. Some few state organizations are making plans for scientific meetings and some of the national medical organizations are holding regional scientific meetings in the various parts of the United States instead of the usual annual assembly, at which war subjects, and industrial and tropical medicine are the main features.

The Shawnee County Medical Society, host to the meeting, has planned for a dinner on Saturday night, May 8th at the Jayhawk Hotel Roof Garden, to be followed by a business meeting. The Sunday session, May 9th will probably be an all day affair. Plans have been made to facilitate the meeting by having the Reference Committee make brief reports and therefore the reports of the Councilors and Committee Chairman are being published in full in another part of this issue of the Journal. The reports of Dr. Henry N. Tihen, President and Dr. Geo. M. Gray, Treasurer, will be read in full at the meeting.

The management of both the Kansan and the Jayhawk Hotels have advised the Society that reservations must be made as early as possible because of the great shortage of rooms available in Topeka over the week-ends. Reservations may be made direct or by contacting the central office as soon as possible.



HENRY N. TIHEN, M.D.

THE RETIRING PRESIDENT

Dr. Henry N. Tihen, retiring President of The Kansas Medical Society, has won the respect and admiration of every member of the Society for his capable leadership during a most difficult year. The duties of the President in ordinary years are time consuming and require a great sacrifice for both the physician and his family, but in the past year with the war situation, legislative difficulties and the need for the selection of a new Executive Secretary for the Society in addition to two new employees in the central office force, have added greatly to the responsibility the President must assume in the guidance of Kansas medicine.

Although Dr. Tihen had little or no legislative experience preceding his election, with the assistance of Dr. Loveland and Dr. J. L. Lattimore and some of the other members, the Society was able to report a most successful legislative year.

For his choice and the distribution of committee memberships throughout the State, he is to be congraulated, as the reports of the committees in another part of this issue of the Journal will testify. In addition to the twenty-two standing committees he created three new committees which are as follows: the Committee on Control of Appendicitis, the Committee on Conservation of Hearing and the Committee on Plasma. Many of the committees have not been as active as in former years due to the rationing of tires and gasoline and the additional duties of a nation at war, while others formerly less active have found their duties increased many fold.

Shortly after Dr. Tihen assumed his new duties as the President, the Kansas Officers Recruiting Board, for the commissioning of medical men in the armed forces was opened, with offices in Topeka. The Board, during its stay in Kansas, granted commissions to 102 men in the State. Under the direction of Dr. Forrest L. Loveland of Topeka, Kansas. Chairman of Procurement and Assignment, assisted by his district committee, a survey was completed for the National Procurement and Assignment Committee, giving the ratio of physicians to the population in the State.

Kansas has 568 men in the service of the United States Army, Navy, Air Corps or Marines. The State, to date, has not been allotted a quota for 1943 due, no doubt, to the fact that her quota was most ade-

quately taken care of in the previous year. The list of Kansas men in service was published in the December 1942 and January 1943 issues of the Journal.

Dr. Tihen has had the most kindly assistance of Dr. F. C. Beelman, Secretary of the Kansas State Board of Health in working with the Society and much of the post graduate work and committee activities have been aided by the various State Directors of the Board.

Those who worked with Dr. Tihen realized his great interest in the welfare of national and state medicine. He took part in many conferences, attended and spoke at national, state and county meetings, and spent a great deal of time in the central office directing and guiding state medical interests. His correspondence was voluminous in behalf of the profession and the Society. The Kansas Medical Society has indeed been conscientiously and thoroughly directed by a most able leader and Dr. Tihen's name can well be added to the list of outstanding Presidents of the Society.



JOHN L. LATTIMORE, M.D.

THE NEW PRESIDENT

The medical profession of the State of Kansas welcomes Dr. John Lee Lattimore of Topeka as its new President for 1943 and 1944.

Dr. Lattimore was born in Fort Worth, Texas in 1894. He obtained his degrees from Texas Christian University of Dallas and Baylor University College of Medicine in 1918. He served in the medical corps during World War I and on return practiced first in Louisville, Kentucky and then in Fort Worth, Texas. In 1922 he came to Topeka.

Dr. Lattimore is at the present time pathologist for Christ's, Jane C. Stormont and St. Francis Hospitals of Topeka. He is the owner and director of the Lattimore Laboratories of Topeka, El Dorado, Sedalia, Missouri and McAlester, Oklahoma.

He is a Fellow of the American Medical Association, and a Diplomate of the American Board of Pathology. He served as President of the American Society of Clinical Pathologists in 1941 and 1942 and as Councilor for that society preceeding his term as President. He is a member of the Board of Directors of the Kansas Group Hospital Service, Inc., and a member of the Board of Regents of the Washburn Municipal University of Topeka and has been a member of the Kansas State Board of Health for several years.

President Lattimore has been closely connected with the work of The Kansas Medical Society, having been Councilor for the Fourth District for two terms, the maximum time permitted, and President of the Shawnee County Medical Society in 1927. He has served as Chairman of the Society Committee on Legal Medicine and as a member of the following State committees: Allied Groups to Medical Practice, Automobile Accidents and Fractures, Control of Cancer and the Stormont Medical Library. Dr. Lattimore was the associate editor of the Journal from 1933 to 1936 in charge of the section on Laboratories. He has given active and valuable assistance in the recent session of the Kansas Legislature. All of this experience will undoubtedly be of great value to the Society and to himself in his year as President.

War matters of great importance to the Society are pending, additional post graduate work in industrial medicine, material and child welfare problems, venereal disease control for the State, and the procurement and assignment of physicians with its added possibilities of professional shortage and re-location, and the always threatening epidemics of war time will demand of our President many wise decisions. In selecting Dr. Lattimore as President, the Society has chosen a capable and dynamic leader and pledges him full cooperation and assistance.

WOMEN'S FIELD ARMY FOR CONTROL OF CANCER

In 1936 the American Society for Control of Cancer, realizing the importance of educating the public through various lay organizations established the Women's Field Army.

The Field Army is a practical working unit guided primarily by the medical profession. The American Society for Control of Cancer and the Women's Field Army, together with the trained medical personnel of the United States have organized their fight against cancer, which has resulted in an educational campaign for the finding and diagnosis of cancer in its early stages. Since the curing of cancer must be undertaken in its early stage, the practical value of the Women's Field Army with its lay educational program for control of the disease is evident and much progress is being made.

The Kansas Womens Field Army which was first organized in 1938, has sponsored various educational programs such as "Cancer of the Skin and Buccal Cavity", "Canver of the Breast and Uterus", and "Cancer of the Stomach". Hundreds of meetings have been sponsored and held annually in the State, with members of the Society as guest speakers. At the present time Mrs. J. E. Johntz of Abilene is the State Commander of the Kansas organization. Mrs. Johntz succeeded Mrs. Donald Muir of Anthony, the former State Commander, who resigned to accept the position of Deputy Commander of the National organization in 1942.

In cooperation with The Kansas Medical Society and the Kansas State Board of Health, the Kansas Women's Field Army has accomplished a great deal in its educational campaign in the past five years. Bulletins, brochures, pamphlets, posters and movies have been furnished for the educational movement. The Journal has published a series of articles on the subject, speakers have been secured for both State and district meetings, State exhibits on cancer have been shown and post graduate assemblies for the education of the professional group in the State have been conducted. The Kansas organization has endeavored to give instructions on the early danger signs of the disease and the importance of yearly physical examinations, including rectal, pelvic and breast examinations. They have advocated the importance of consulting your family physician in all possible cases.

It is hoped that all physicians will again cooperate in the 1943 enlistment campaign. Membership in the organization is only $1.00 per year. The program is financed with the money that is secured in the yearly enlistment campaign and it is indeed a worthy cause.

Pittsburgh Civilian Defense medical groups are now locally known as "mercy teams," which seems a very pat title for these groups. It is a name easily remembered and soon should become a by-word in that city.—Journal of the Indiana State Medical Association.

NEWS NOTES

COUNCILOR ANNOUNCEMENT

Dr. Henry N. Tihen, President, has requested that we announce the importance of the election of Councilors to the following Districts at the annual meeting to be held in Topeka on May 8-9, 1943:

The death of Dr. Herbert Atkins of Pratt, Councilor for the Eleventh District and of Dr. Geo. O. Speirs of Spearville, Councilor for the Twelfth District, will necessitate the election of Councilors to fill both of these vacancies. Dr. Speirs, had he lived, would have completed his second term as Councilor.

Councilors will be elected for the Third District and the Sixth District as Dr. L. D. Johnson of Chanute and Dr. W. P. Callahan of Wichita have each completed two terms as Councilor. In the Tenth District, Dr. O. A. Hennerich of Hays has completed his first term in office.

DELEGATES TO STATE MEETING

The following information may explain the situation to the county medical societies of the State in regards to the number of Delegates for the annual meeting to be held in Topeka on Saturday, May 8th and Sunday, May 9th, 1943.

The Constitution and By-Laws of The Kansas Medical Society, Chapter V., Section 3, states as follows: "Each component society shall be entitled to send to the House of Delegates each year one duly qualified delegate for every twenty members, and one duly qualified delegate for each major fraction thereof: Provided, that each component society which has made its annual report and paid its assessments as provided in this Constitution and By-Laws shall be entitled to at least one duly qualified delegate."

Members serving in the Armed Forces and listed as members of the component society can be used in counting the number of delegates.

A.M.A. MEETING

The annual session of the House of Delegates of the American Medical Association will be held in Chicago, Illinois on Monday, June 7th, 1943. The President-Elect will be installed as the new President at a meeting to be held at 8:00 p. m. on Tuesday, June 8th. No scientific assembly is scheduled for the meeting.

KANSAS OBSTETRIC AND GYNECOLOGICAL SOCIETY MEETING

The Kansas Obsterical and Gynecological Society held a dinner meeting in Wichita on April 6. The meeting, although sponsored by the Kansas Society was in conjunction with the monthly meeting of the Sedgwick County Medical Society.

Speakers were: Dr. Buford G. Hamilton of Kansas City, Missouri who discussed "Obstetrics" and Dr. Harold L. Gainey of Kansas City, Missouri who discussed "Gynecology". Dr. Hamilton is Associate Professor and Dr. Gainey is Assistant Professor of Obstetrics and Gynecology of the University of Kansas School of Medicine. A round-table discussion at 4:00 p. m. preceded the dinner meeting.

PHYSICIANS WANTED

The office of the Surgeon of the Seventh Service Command has requested that we publish the following information to our readers:

"Physicians are wanted, both male and female, as contract surgeons at Army-operated industrial plants and depots in the states of Colorado, Missouri, Nebraska, Kansas, and South Dakota. Pay with dependents, is approximately $3,400 per annum. For further information address: The Surgeon, Headquarters Seventh Service Command, Federal Building, Omaha, Nebraska.

INVALID DIETS AND RATIONING

Dr. Russell M. Wilder, Chief of the Civilian Food Requirement Branch of the United States Department of Agriculture of Washington, D. C., has recently requested that we release the following information to physicians regarding Rationing Order No. 13, issued by the Office of Price Administration on February 9, 1943. The order covers all canned, dried, and frozen fruits and vegetables. Article XX, Section 2.5 of the order pertains to diets for patients and is of interest to physicians.

"Consumers who need more processed foods because of illness may apply for more points. (a) Any consumer whose health requires that he have more processed foods than he can get with War Ration Book Two, may apply for additional points. The application must be made on OPA Form R-315, by the consumer himself or by someone acting for him, and may be made in person or by mail. The application can be made only to the board for the place where the consumer lives. He must submit with his application a written statement of a licensed or registered physician or surgeon, showing why he must have more processed foods, the amounts and types he needs during the next two months, and why he cannot use unrationed foods instead. (b) If the board finds that his health depends upon his getting more processed foods, and that he cannot use or cannot get unrationed foods, it shall issue to him one or more certificates for the number of points necessary to get the additional processed foods he needs during the nxt two months."

GOLDEN-BELT MEETING

The Golden-Belt Medical Society held a meeting on April 8 in Junction City, with the Riley County Medical Society as host.

Speakers for the meeting were as follows: Dr. Barrett A. Nelson of Manhattan discussed "Salpingography in Relative Sterility"; and a medical officer from Camp Phillips spoke on "Menningitis"; Dr. Peter T. Bohan of Kansas City, Missouri discussed "Errors in the Evaluation of the Electrocardiagram" and Dr. F. L. Loveland of Topeka, Chairman of the Procurement and Assignment for Kansas, spoke on "Procurement and Assignment".

"Color blindness is a congenital (existing at or before birth) defect and in the true sense of the term is never acquired," The Journal of the American Medical Association for November 28 says in answer to an inquiry. "Extraneous conditions . . . have no influence on the color perception, which may vary from complete absence of color recognition to mere inability to differentiate various shades. There is no known correction for this condition despite the claims of some optometrists."

OFFICIAL PROCEEDINGS

Foreword to Delegates

Since the 1943 annual session of the Society is to be only a brief business meeting and time for such is greatly limited, an attempt has been made to include in this issue of the Journal as many reports as possible, thus conserving the time necessary to read such reports in full.

Delegates are, therefore, requested to familiarize themselves with the reports in advance of the meeting.

The following is the report submitted by F. R. Croson, M.D., Secretary of The Kansas Medical Society:

To: The House of Delegates:

The past year has been interesting, inspiring, instructive and busy. The Conference of Secretaries and Editors in Chicago last November was novel and was based largely on the needs of the war program in connection with medicine and on pre-payment plans which have been adopted by a large number of the state societies. These plans will probably enter into the post war period very materially for all of us. One could not listen to Colonel Fred Rankin, Rear Admiral Ross T. McIntire, Dr. Frank H. Lahey, Brigadier General Charles C. Hillman, Dr. James E. Paullin, Surgeon General Thomas Parran, Colonel Leonard G. Rowntree and a host of other capable speakers without being inspired by their messages. We heard a lot about the Procurement and Assignment and we fellows from Kansas were indeed proud of our State and also of our Procurement and Assignment Committee.

Routine work was carried out as usual during the year. We were faced with the problem of re-organization of the central office to some extent by the enlistment into the armed forces of Mr. Clarence Munns, our Executive Secretary. We all felt the loss of Clarence greatly but his office was filled by Mr. Robert Brooks, after careful elimination of a number of well qualified applicants. Bob has done and is doing a most excellent job; he is not Clarence Munns but he will be just as valuable when he has gained more experience. The Society is just as fortunate to have him in our employee as they were to obtain Clarence Munns eight years ago.

The legislative session presented many problems. During the past session we have made and have held the friendship of a large group of men in both the Senate and the House of Representatives. Too much praise and gratitude cannot be given to Dr. Henry Tihen, Dr. Forrest Loveland, Dr. John Lattimore and a rather large group of others who spent their valuable time and effort for the Society during the legislative session. Dr. Tihen spent weeks at a time in Topeka, Dr. Loveland and Dr. Lattimore spent hours away from their work every day and a large per cent of their evenings were spent in contacting old friends in the Legislature and in making new ones. A general knowledge of medicine and the ideals and aims of medicine is reflected in the attitude of a large number of the Legislators. This is the harvest we are reaping from the

seeds so carefully and truthfully sown by Clarence Munns and the men who have so generously given of their time during the past few legislative sessions.

If the war is over in 1945, it might be well for Kansas medicine to get away from the defense that we have always assumed and take the offense. Such is the attitude of a number of men in our Society. Why not take the ball ourselves? Why not make our standards so high in Kansas that they will be out of range of the cultists and be an example for other states to follow? I believe these are urgent problems for the future.

I have greatly enjoy my year of service. The more one learns of Kansas medicine, the more he appreciates that we have a most outstanding Society. The Kansas Medical Society has become a great and a powerful organization due to capable leadership and to unity and co-operation of its members.

Respectfully submitted,
F. R. Croson, M.D.
Secretary.

The following is the report of the Councilor of the First District:

TO: THE HOUSE OF DELEGATES:

Counties	In County	Active	In Service	Members
Atchison	14	12	7	9
Brown	7	7	2	7
Doniphan	6	4	1	5
Jackson	5	4	2	1
Jefferson	9	7	2	7
Marshall	16	14	2	12
Nemaha	12	11	2	13
Pottawatomie	12	11	None	10
TOTALS:	81	70	18	64

Medical meetings are held less often than usual in keeping with conservation of rubber program. Consistant with the war effort the medical profession is doing a good job of caring for the public in this District. There are cult problems in three counties in this District.

Respectfully submitted,
J. W. Dandell, M.D.
Councilor, First District.

The following is the report of the Councilor of the Second District:

TO: THE HOUSE OF DELEGATES:

Most of the business concerned with medical society affairs this year has been handled by correspondence. Societies in the District have been kept informed of essential facts and their problems referred to proper sources for consideration.

Respectfully submitted,
O. W. Davidson, M.D.
Councilor, Second District.

The following is the report of the Councilor of the Third District:

TO: THE HOUSE OF DELEGATES:

During the last year have had perfect co-operation and no complaints of any kind to require the act of a Councilor in southeast Kansas, District Three.

I wish to extend my appreciation for the privilege of being your Councilor for the last six years and trust that you may appoint another who may be a much better Councilor than I. Because of sickness in my family I have been unable to attend a lot of your meetings during the last year.

Respectfully submitted,
L. D. Johnson, M.D.
Councilor, Third District.

The following is the report of the Councilor of the Fourth District:

TO: THE HOUSE OF DELEGATES:

During the past year there have been no unusual circumstances in any of the societies in this District. The drain upon the personnel for the armed forces has forced all remaining physicians to be definitely occupied at all times with the pursuit of their routine work. All the men in the District have been very co-operative in the legislative problems just past.

There are still a number of communities who have no physician in this District and all efforts to procure physicians for those communities have failed.

Respectfully submitted,
Philip W. Morgan, M.D.
Councilor, Fourth District.

The following is the report of the Councilor of the Fifth District:

TO: THE HOUSE OF DELEGATES

On account of the situation which every doctor in Kansas fully understands there have been no personal visits made to any of the county societies in the Fifth Councilor District.

The local societies, however, are active and there has been a perfect spirit of cooperation in furthering the war effort and activities of the year.

Respectfully submitted,
John L. Grove, M.D.
Councilor, Fifth District.

The following is the report of the Councilor of the Sixth District:

TO: THE HOUSE OF DELEGATES

Everything has been moving along fairly well in the Sixth District. The different societies have had their meetings regularly and the attandance has been very good considering the number of men who have gone to the armed service. The medical procurement has drawn rather heavily on the men in this District as it has in the others.

There is considerable complaint from various parts of the District, a great majority of the societies, and the men individually, who are insisting upon stricter inforcement of the Medical Practice Act. We all hope that this will be accomplished in the near future.

Respectfully submitted,
W. P. Callahan, M.D.
Council, Sixth District

The following is the report of the Councilor of the Seventh District:

TO: THE HOUSE OF DELEGATES:

I herein wish to offer my report of conditions in the Seventh District during the year just concluded.

It is to be regretted that during this period there has been little or no opportunity to personally visit the re-

spective county societies, but I have attempted through correspondence to obtain certain information which I hope may be helpful to you, in your proper appraisement of conditions in my district.

Clay County: population 12,500, has ten physicians. There have been three members join the armed forces of the United States. There is no actual shortage of physicians in this county. During the last year Clay County lost one of its most loyal, capable and best loved members, a loss that will be keenly felt by a very large percentage of physicians of Central Kansas, when Dr. C. C. Stillman of Morganville died. Clay County has at no time used the Farm Security Administration plan of medical care. Scientific and business meetings are held regularly except during the hot summer months. The secretary instructs me that their interest in the societies activities has been generally good. Their physician membership in the society is 100 per cent.

Washington County: population 15,000, has seven physicians, now actively practicing there. They have lost three physicians to the armed forces of the United States. The secretary does not feel any actual shortage of physicians exists in this county, though they are often short handed. They have lost no physicians through death. The Farm Security Administration plan of medical care has not been tried in this county. Their society holds regular monthly meetings, and consider the interest good. During the past year they have completed their diphtheria immunization, small pox vaccination, and their tuberculin testing program throughout the county. They have 100 per cent membership in the society.

Cloud County: population 17,000, has fifteen physicians. They have lost four to the armed services of the United States. No shortage of physicians exists in the county. The Farm Security Administration plan of medical care is being tried here with varied reports as to satisfaction both as to patients and physicians. There are usually one or two scientific meetings during the year and they are quite large and very well attended. At the last such meeting held at the St. Joseph Hospital at Concordia, they had a total attendance of thirty-seven, and the meeting was considered very unusual. Perhaps they have something here, in only having an occasional meeting, but making it really worth while. Cloud County has but two physicians who are not member and one of these is not well physically.

Republic County: population 10,000, has nine physicians. They have lost one physician to the armed forces. The secretary reports no actual shortage of physicians in the county. No physicians have died in this county in the past year. The Farm Security Administration plan has been tried during the years of 1940, 1941, 1942 and the present year, and it is reported not being satisfactory to patients or physicians. Monthly scientific meetings are held except during the hot months, and they report good attendance and interest. There is only one physician here who does not belong to the society.

Mitchell County: population 10,000, has eleven physicians. They have supplied one physician to the armed services. Their secretary reports no shortage of physicians exists. There have been no deaths during the year. The Farm Security Administration plan is now being tried, and it is reported as being satisfactory to both patients and physicians. Mitchell County society holds regular monthly scientific meetings, and also, can boast a 100 per cent membership in the society.

Jewell County: population 10,000, has nine physicians. Two of the nine are not very active and one other is a specialist. They have sent no member to the armed forces. The secretary says there is no shortage of physicians in his county. There is a genuine regret at the death of the following physicians in this county during the past year: Dr. J. E. Hawley of Burr Oak, age ninety years, who has served as President of the Jewell County Society for a number of years, and Dr. S. Dykes of Esbon, age seventy years, who has been county health officer for years. The Farm Security Administration plan has been employed for three years and it is reported satisfactory to the patients and all the physicians excepting one. Jewell County society does not hold its scientific meetings regularly, but rather attends such meetings at Concordia and Beloit. However, they have held three very good scientific meetings this year. The physicians in this county have completed the diphtheria immunization, the small pox vaccination, and the tuberculin testing over the entire county. There are two physicians practicing in this county who do not belong to the society.

Riley County: population 20,000, has eighteen physicians, three of these are at Kansas State Student Health Department and one is full time health officer. Riley County has lost four physicians to the armed service. No actual shortage of physicians exists here. We regret the death of Dr. A. G. Henderson, age eighty-one of Leonardville, where he has practiced for very many years. The Farm Security Administration plan has not been tried here. It has been the intention to hold a scientific meeting here every month, however, at times we have been unable to hold it that frequently. There is splendid interest shown here by our entire membership and much reason to expect continued good conditions in our society.

You will please note there is no lack of physicians in any county in this district, as reported by the secretaries of such societies.

Respectfully submitted,
R. R. Cave, M.D.
Councilor, Seventh District.

The following is the report of the Councilor of the Eighth District:

TO: THE HOUSE OF DELEGATES:

Because of gas rationing I did not visit all of the societies in my District. I did, however, visit the Saline County Medical Society and the Central Kansas Medical Society and found both functioning well.

I had a request from the Saline County Society to investigate the qualifications of several members of their society to become Honorary Fellows in the American Medical Association. We learned that only doctors of medicine living outside the United States were entitled to Honorary Fellowship. We also learned, however, that the By-Laws of the American Medical Association provide for an Affiliate Fellowship for all those who have been Fellows for fifteen years or more, who have attained the age of sixty five years and who have been made honorary members of their state societies. Affiliate Fellows pay no dues nor do they receive the Journal of the American Medical Association except on personal subscription. The nomination for this form of fellowship must come from the state society and must be presented to the House of Delegates of the American Medical Association at an annual meeting. Only one of the applicants, Dr. J. W. Neptune of Salina, qualified.

Dr. B. A. Higgins, member of the Legislative Committee from this District, and I did what we could, through cor-

respondence and otherwise, to further the cause of the Society at the last election.

Your Councilor for the Eighth District attended all called meetings during the past year except one.

Respectfully submitted,

Ben H. Mayer, M.D.
Councilor, Eighth District.

The following is the report of the Councilor of the Ninth District:

To: The House of Delegates:

There have been no special or acute medical problems in the Ninth Councilor District this year.

Generally speaking, I believe that the people have had adequate medical care. This has meant longer hours for ach doctor in the District.

Classes in first aid, sponsored by the American Red Cross, have been conducted by the doctors over the District.

As a measure to conserve gas and rubber, there has been only one meeting of county medical society in this District.

Respectfully submitted,

Haddon Peck, M.D.
Councilor, Ninth District.

The following is the report of the Councilor of the Tenth District:

To: The House of Delegates:

Another mile stone has passed running in smooth harmony and coordination. It has been a very great pleasure to represent the Tenth District. I have had assistance for the asking and co-operation on all problems. I am very appreciative in being able to report "All's Well."

Respectfully submitted,

Otto A. Hennerich, M.D.
Councilor, Tenth District.

The following is the report of the Twelfth Councilor District:

To: The House of Delegates:

Owing to the recent death of George O. Speirs of Spearville, Councilor of the Twelfth District, I have been asked to make a report for that District. This report will of necessity be rather short and somewhat incomplete. Dr. Speirs has looked after the interest of all the doctors as well as the lay population in this District so completely and efficiently that the rest of us only did what he suggested and without his suggestions, we are very much at sea. However, he continued his good work up to within a few days of his death and things were so well taken care of that up to the present time, all has been going well. His loss will be felt more in the future than we now realize. One of his main principles has been to take care of the interests of the doctors but never forgetting his obligations and the obligation of all the doctors of the District to the community which is being served by them. His loss has been felt very keenly by the doctors but I believe more so by the community in which he lived. He might be described as always reliable, sincere and dependable with the judgment which we all learned to respect.

This District is still in need of a few more doctors. There has been some effort made to cover the territory the best we can but this has been very difficult owing to the increase in population in the last two defense centers, namely Garden City and Dodge City.

The Ford County Medical Society has remained quite active and has formed a nucleus around which we have continued to work and keep the activities of the District functioning.

The Farm Security program has been approved and will continue for another years with some rather important changes, namely the price which was increased about thirty per cent. Its need is quite questionable owing to the good crops and good prices; also the war activities have increased the work in some parts of the District to a noticeable degree.

One activity that Dr. Speirs started but has not been completed was a more uniform contract with the counties for taking care of the county work. This is not quite such an important part of our work at the present time as in the past but it certainly should not be forgotten for the Utopia has not yet arrived and the time to prepare for war is in the time of peace.

The nation is at war and the practice of medicine is at peace, with plenty of work and money never more plentiful. I believe our medicial Society should be more active and give more consideration to the future as the future does not look too bright. The professional side of medicine, of course, is of first importance but the business side should not be neglected in any medical organization and I do not mean the business of the Society but the financial part as it affects the individual doctor as well as the standing of the medical profession in the community.

The initiative in all questions of medical care should be taken by the medical Society and not left to the Red Cross, social security, politicians, or whatever group that may appear, who uses this as a means of advancing their own personal interests and detrimental to the doctors and usually detrimental to the public as a whole. I am for more business in county medical societies.

Respectfully submitted,

G. R. Hastings, M.D.
Reporting for Twelfth District.

The following is the report received by Harry Lutz, M.D., Chairman of the Committee on Appendicitis:

To: The House of Delegates:

There has been no meeting of the Committee and hence there is no report to make.

The following is the report submitted by H. M. Glover, M.D., Chairman of the Committee on Automobile Accidents and Fractures:

To: The House of Delegates:

Your Committee on Automobile Accidents and Fractures reports some very interesting and valuable activities in the field of work assigned. No regular called meeting of this Committee was held during the current year because of the difficulties of travel.

This Committee sponsored a scientific exhibit at the eighty-third annual session of The Kansas Medical Society in Wichita, on May 11 to 14 inclusive, featuring an exhibit of large photographs both interesting and instructive, of highway accidents furnished by the Kansas State Highway Patrol. We had at our booth a special display prepared by the Highway Patrol showing the articles carried by the cars of these officers for use in emergency. We also had two demonstrations daily at our booth of proper application of plaster casts. This work was handled by

A. E. Bence, M.D., Charles R. Rombold, M.D., and H. O. Anderson, M.D., all of Wichita.

As it seemed probable that there would be no official meeting of this Committee during the year for reasons above stated I had carefully written all members of the Committee and urged them to spend some time at the Committee's booth which most of them did and in that way there was opportunity for exchange of ideas and planning of the work of the Committee.

I also wish to report that there was published in the August number of the Journal of The Kansas Medical Society an article on "Tests to Determine Alcoholic Intoxication" by Willis H. McKean, M.D. of Kansas City, a member of my Committee. Dr. McKean had been assigned this particular subject to investigate for the Committee and he had done a lot of study and research and his well worked out, logical, clear and interesting presentation is a matter of pride to your Committee.

The following is the report submitted by C. Omer West, M.D., Chairman of the Committee on Auxiliary:

To: The House of Delegates

It is with pleasure that the Auxiliary Advisory Committee reports a most active Auxiliary during the past year in spite of a decreased membership due to the fact that so many members have gone with their husbands who are in the service.

The Legislative Chairman has kept in close touch with matters before the Legislature this year, ready to be of service if called upon. She has urged education of the membership along these lines.

Nutrition and allied war matters have received attention by nearly all county groups. One public relations tea was held and some of the women are markedly active in a constructive way in the cancer control movement.

The program this year has been much the same as last year, plus a greater activity along lines connected with the war.

The Committee is proud of the fact that the Auxiliary has been able to carry on this year in spite of many handicaps and feels that the medical profession should give them all the assistance possible in the different communities.

The following is the report submitted by Paul E. Belknap, M.D., Chairman of the Committee on Child Welfare:

To: The House of Delegates

Due to war conditions the Committee on Child Welfare has been relatively inactive. Two meetings have been held, but only a few members were able to attend either meeting.

Dr. Fred B. Mayes of the Kansas State Board of Health, Division of Child Welfare, was elected Secretary and has given valuable assistance especially in the presentation of child welfare exhibits and lectures to the lay groups, particularly those of the Kansas State Teachers Association, and the Kansas Parent Teachers Association.

No comprehensive work on the study of child morbidity and mortality in the State can be done until tabulating machines can be obtained by the Board of Health.

A bill for compulsory vaccination for small pox and immunization against diphtheria was introduced into the Legislature, but no action was taken on it. It is felt that this is an important need, and that further action should be taken as soon as possible.

The rules and regulations for the control of communicable disease are being revised at the present time by Dr. F. C. Beelman, Secretary of the Board of Health, and will be presented to the Committee for approval. A code similar to that of the United Public Service will be adopted and will eliminate the present needless quarantine of many of the minor communicable diseases.

It is felt that recommendations concerning the modifications of measles by immune serum should be postponed until more data concerning its efficiency could be obtained.

No recommendation was made in regard to issuance of a bulletin to the county medical societies concerning tetanus immunization. This is an important subject, and action should be taken by the next Committee.

Some work has been done in the State in regard to the study of the Kenny system of treatment for poliomyelitis. Nurses who have had special training in treatment in the acute stage are available at most of the Crippled Children's Orthopedic Centers. More nurses should be trained so that their services could be made available to the whole State.

At a joint meeting with the Committee on Maternal Welfare it was decided to recommend to the Council that they accept the offer of the United States Children's Bureau for financial aid in the obstetrical and postnatal care of the families of enlisted men in the armed forces. A schedule of fees for pediatric care during the first year was made.

The following is the report submitted by C. C. Nesselrode, M.D., Chairman of the Committee on Control of Cancer:

To: The House of Delegates

The Cancer Committee continues to carry forward its educational campaign in association with the Women's Field Army.

Mrs. Daisy Johntz, of Abilene, is State Commander of the Women's Field Army and is doing an excellent job of organization work. The month of April is enrollment month and, therefore, the financial success of the work cannot be reported until sometime about the middle of May. Many public meetings are being held, the exact number cannot be reported. In spite of the fact that everyone is interested in the war and so many distracting activities, the attendance at the meetings has been excellent and the interest shown is surprisingly great.

The 'around the State tour", that has been conducted for several years and had for its primary object professional education, is not being caried forward this year.

We are encouraged to believe that the Committee will be able to hold the interest of the public previously engendered and be in a position to carry forward effectively at the conclusion of the many distracting interests.

The following is the report submitted by E. N. Robertson, M.D., Chairman of the Committee on Conservation of Eyesight:

To: The House of Delegates

The Committee on Conservation of Eyesight has had under consideration the following activities for the year of 1942-1943.

1. Continued assistance in the blind program of the Kansas State Board of Social Welfare.

2. Conferences with the Kansas State Department of

Education and the Kansas State Teachers Association as to the possibilities for instituting a more extensive conservation of eyesight program in Kansas schools.

3. Development of additional lay educational programs on conservation of eyesight. Consideration of the possibility of preparing a special program of this kind for Kansas industry.

4. Investigation of plans and sources through which eye glasses may be more easily furnished to indigent persons.

5. Inspection of the Kansas State School for the Blind, and if such is desired, preparation of recommendations thereon for the Kansas State Board of Regents.

6. Study of prices charged for eye glasses, and of the policy of opticians paying commisions to oculists and optometrists.

Due to the difficulty of transportation no formal meeting of the Commitee has been held so far but one is planned during the State business meeting in Topeka in May. However, the Chairman has had conferences with representatives of the State Department of Social Welfare and has discussed matters of interest with the State Supervising Ophthalmologists, Dr. Kirkpatrick and Dr. Reed. He has also had correspondence with one or two other members of the Committee.

An examination of the eyes of the grade school children has been made in several Kansas towns with cooperation and assistance of members of this Committee.

Cooperation and assistance has been extended to the Parent Teachers Association in the examination of the eyes of grade school children.

The Committee's activities have necessarily been curtailed by the conditions incident to the war, but we will have more to report after our meeting in May.

The following is the report submitted by J. Stanley Reifsneider, M.D., Chairman, of the Committee on Conservation of Hearing:

To: The House of Delegates:

This Committee held no meetings during the past year.

A complete survey of the conservation of hearing programs in the other states has been made and a large amount of information on activities of similar state and national medical and lay organizations assembled by Colonel Lyle Powell, former Chairman of the Committee, prior to reporting for active duty in the United States Army.

Hearing aids have been studied and lay organizations contacted.

The following is the report submitted by C. H. Lerrigo, M.D., Chairman of the Committee on Control of Tuberculosis:

To: The House of Delegates

The Committee on Control of Tuberculosis held a brief meeting at Wichita on May 13, 1942 and a full meeting of the Committee at Topeka on August 9, 1942. This does not cover all Committee activities for much has been done by correspondence, and sub-committees have met frequently with the Legislative Council and with the Kansas State Board of Health. Your Committee can therefore report that it has given some attention to each of the eight points of its suggested program as recorded on page 301 of the July, 1942 issue of the Journal and special consideration to certain urgent subjects.

We received excellent attention from the Legislative Council with most helpful consideration from its Secretary, Dr. F. H. Guild. The 1943 Legislature passed House Bill 324 and 325 which worked out by your Committee in cooperation with the State Board of Social Welfare.

Dr. C. F. Taylor worked up a revised list of Kansas physicians prepared to give pneumothorax refills.

Representatives met with your Committee on Scientific Work on September 15, 1942 in their meeting for post graduate medical study.

Arrangements are in progress through Dr. Taylor to provide an educational program for physicians, coming in small groups for "refresher courses", at the Norton Sanatorium.

Approval was given to the operation, by the State Board of Health, of photoroentgen unit for the special purpose of chest x-ray of defense workers, being a screening process whereby suspicious cases might be brought to notice, reference made to local physicians for treatment, and spread of tuberculosis controlled among the workers and their families.

Throughout the year material in reference to tuberculosis control has appeared in each issue of the Journal.

The following is the report submitted by A. W. Fegtly, M.D., Chairman of the Committee on Constitution and Rules:

To: The House of Delegates:

This Committee must confess inactivity during the past year. This has not been due to lack of interest, and we think excusable on account of two factors; first, the added stress of local medical work and considerable national defense work, and second, since a full scientific session this year was uncertain, and only a delegates meeting decided upon at a late date, we agreed with the President that it might be best to curtail the work of the House of Delegates to the absolute and important present essentials.

We beg indulgence for procrastination, therefore, and report only the following suggestions.

1. Continuation of the arrangement of the past three years for temporary Special Reference Committees for reports of officers and committees.

2. We recommend that early in the year the new Committee prepare and publish for consideration and vote at the 1944 session the following important and advisable amendments to the By-Laws:

a. Chapter 1 Section 4: Change in the section relative to Honorary Members.

b. Chapter 1 Section 5: To be added a provision for associate membership.

c. Chapter XI Section 1 and 2: Revision to include Reference Committees for report of officers and councilors (except President and Treasurer) and also Reference Committee on committee reports.

e. Inclusion in list of standing committees, the Committee on Control of Heart Disease and any other working committees that have become more or less permanent in character.

3. We ask that the officers and councilors consider the advisability of changing the Constitution, Article VI Section 1, so as to include the First Vice-President in its membership.

No action on these is possible at this meeting since it has been impossible to prepare them in time for publication, and all are of sufficient importance to merit consideration by the membership.

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With due apologies to the members assigned to this Committee and to the House of Delegates this report is submitted.

The following is the report submitted by L. S. Nelson, M.D., Chairman of the Defense Board:

To: The House of Delegates:

Your Defense Board wishes to report the most successful year, so far as the number of cases defended, during the tenure of office of the present Chairman of the Board.

Expenditures for 1942 were $1,068.16; thus far this year $287.07 has been spent. The details of these expenditures are on record in the central office in Topeka and are available to any member who might desire to know exactly how the money has been disbursed.

Again it seems well to call your attention to a few points concerning malpractice proceedings.

1. We can only defend bona fide members of our Society living within our State, which means that the member's dues must be paid.

2. There are two types of cases which seem most expensive and most apt to need defense. The first is the alleged improper use of x-ray in treatment; the second is in the care of fractures.

Your Defense Board believe that in relation to the first the practitioners who are using the x-ray in treatment should probably acquire from the patient a signed release after explaining the dangers of the use of such an agent, especially where heavy doses are needed. Forms for this purpose are available or can be printed. In the matter of fractures we believe that a careful survey of the probable outcome and an honest appraisal given to the patient or his family or both will often obviate dissatisfied individuals.

We are quite certain that, if our members use the Golden Rule with reference to remarks made concerning a fellow practitioner and would only talk in a way they would like to be talked out, it will minimize the defense program to a greater extent.

The Defense Board also believes that professional help, such as nurses and technicians, should be carefully selected with reference to technical training and judgment. A little more paid in salaries to such assistants often means less paid in channels which are injurious to ones reputation.

The following is the report submitted by H. L. Chambers, M.D., Chairman of the Committee on Endowment:

To: The House of Delegates:

The Committee on Endowment has had no meeting this year because of various pressures due to the war. However, there was some correspondence done and some matters more or less considered.

1. The hope for a large gift for the Medical Science Building at the University of Kansas still exists and the Chancellor has presented several excellent ideas for consideration.

2. Some foundation work was done on providing a School of Public Health, rural, including all cities under 25,000 population, but this has been shelved for the time in the interest of larger or more pressing matters.

3. The death of the former Dean of the University, Olin Templin, Secretary of the University of Kansas Endowment Association was a staggering blow to us and our interests.

The following is the report submitted by C. E. Joss, M.D., Chairman of the Committee on Hospital Survey:

To: The House of Delegates

Owing to the gasoline rationing program and he shortage of physicians in the community, no meetings have been held this year. A study, however, is being made of various hospital insurance plans from reports of insurance companies and of hospitals, which will be tabulated later.

The following is the report submitted by J. L. Lattimore, M.D., Chairman of the Committee on Legal Medicine:

To: The House of Delegates

Unfortunately, since Dr. Earl L. Mills the original Chairman of this Committee has entered the service, this Committee has not held a meeting. The purpose is to stimulate a better understanding between the legal profession and the medical profession. When Dr. Mills entered the service, plans were under way for several joint meetings in various parts of the State and it is hoped that during the coming year this program can be carried out.

The following is the report submitted by J. E. Henshall, M. D., Chairman of the Committee on Locations and Medical Distribution:

To: The House of Delegates:

The Committee on Locations and Medical Distribution began its year with Dr. Lee Leger of Kansas City, acting as Chairman. The writer accepted the chairmanship when Dr. Leger entered military service.

The Committee has tried to follow a suggested program as outlined by Dr. Leger but because of the absence of several other members who are also in the service, and because of gas and tire rationing, it was decided by the present Chairman not to call a special meeting of the remaining members but to enlist the aid of Dr. F. L. Loveland, who is Chairman of the Procurement and Assignment Service in Kansas, and who has made many trips and met with representatives of many county societies over the States for purposes that fit into the suggested program of this Committee.

On December 8th, a meeting was held in Topeka with Dr. Loveland and Robert A. Brooks, the Executive Secretary of The Kansas Medical Society, and much useful information was obtained. It is my hope to be able to publish in a later issue of the Journal, the ratio of physicians to the population in each county, the comparative ratio of physicians to the population in the State as compared to other states of similar size and circumstances, the percentage of physicians in each county in the young, and middle age groups, and other additional data wherein the Kansas location problems could be more accurately appraised.

It has been a difficult matter to place physicians in localities where they are much needed but this Committee has made it possible for many desiring a change in location to acquaint themselves with certain facts and other information desirable to them. Many communities in the State which have not formerly been served by a physician are now receiving part-time service in a very satisfactory manner from physicians in neighboring towns.

The Committee hopes at a future date to be able to give a more detailed report of its work on medical distribution in Kansas.



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The few areas which have been stripped of physicians are either being taken care of by doctors of surrounding communities, by virtue of rhe efforts of this committee, or will be taken care of in the very near future.

The following is the report submitted by Ray A. West, M.D., Chairman of the Committee on Maternal Welfare:

To: The House of Delegates:

The first meeeting of the Commirree was held at Wichita, on October 11, 1942. On account of the war time emergency it was found necessary to curtail the post graduate program, assisting the Kansas Obstetrical and Gynecological Society in only one meeting in Wichita in April, 1942, consisting of a one day post graduate program with a guest speaker.

The Committee voted to redistribure the booklet prepared by the Committee on Maternal Welfare on "Minimum Standards of Maternal Care", to Kansas physicians with the hope that it might assist men who found it necessary to resume obstetric practice. In order to assist in every possible manner in maintaining a high standard of obstetric care throughout the State three measures were regarded as important:

1. Mothers training classes to be administered and conducted by rhe Kansas State Board of Health with the cooperation of the local medical societies and given by an obstetric trained nurse teacher. The first series of lectures is being organized at Salina.

2. Desk cards to be placed in the office of Kansas physicians outlining the high lights of standard obstetric procedure.

3. Continued accumulation of the maternal mortality on the report blanks designed by the Committee on Maternal Welfare, in order to have at hand in a few years valuable data with regard to the causes of maternal mortality.

In January 1943, a joint meeting was held with the Committee on Child Welfare, together with other men from key sections. The purpose, of which, was to consider the advisability of a requesr for funds from the childrens bureau for the purpose of caring for the wives and children of men in the armed forces. After much discussion a motion was passed to request such funds, the funds to be obrained and distributed to Kansas physicians through the Kansas State Board of Health. A request for $1,200,000 has passed both Houses of Congress. The Kansas plan is now in the hands of the Children's Bureau awaiting their approval.

The following is the report submitted by W. Stephenson, M.D., Chairman of the Committee on Medical Economics:

To: The House of Delegates:

The Committee on Medical Economics has nothing new to add to their report of last year. The Committee has had no meeting due ro time and transportation, as it is the concensus of opinion that there has been nothing the past year, which would justify calling the group together.

The following is the report submitted by Harry Horn, M.D., Chairman of the Committee on Medical History:

To: The House of Delegates

One year ago when I accepted the Chairmanship of your Commirtee on Medical History, it was my earnest desire to be able to review the archives of The Kansas Medical Society and to obtain from them the necessary data and information for the preparation of a history of The Kansas Medical Society.

Before undertaking this it was necessary for me to complete an assignment upon which I was working at the time. Ordinarily this would have been completed in a few weeks, but unforseen delays arose which have prevented this accomplishment and this must be brought to a conclusion before undertaking another.

The following is the report submitted by Fred J. McEwen, M.D., Chairman of the Committee on Medical Schools:

To: The House of Delegates:

The Committee on Medical Schools has not had a meeting this year. The problems of the Medical School have been concerned with the loss of faculty due to the war and the need for increased speed in teaching schedules for the same reason.

No problems have arisen, which warranted asking our busy members to leave their work, up to this time.

The following is the report submitted by A. E. Gardner, M.D., Chairman of the Committee on Necrology:

To: The House of Delegates:

I wish to inform the Society that the following of our members have died during the year on the dates given and from the causes described. Although the report covers the period from April 1, 1942 to April 1, 1943 rhree members names were not listed in the report last year and are therefore herein listed.

NAME	AGE	DATE	PLACE	CAUSE
Dykes, Spencer B.	72	March 10	Esbon	Chronic nephritis
Collins, David W.	67	March 14	Effingham	
Stewart, Franklin Charles	63	March 27	Eskridge	Coronary sclerosis
Fulton, John S.	69	April 10	Topeka	Cerebral hemorrhage chronic cystitis
Milligan, James A.	86	April 19	Garnett	Caner of the gall bladder
Lathrop, William C.	65	April 27	Norton	Coronary thrombosis
Bremen, Maurice N.	84	May 9	Roxbury	Carcinoma of caecum
Reid, James T.	62	May 14	Iola	Cerebral hemorhage, anemia
Moore, Raymond Wm.	69	May 16	Eureka	Coronary thrombosis acute nephritis
Bruner, Benjamin	63	May 22	Wamego	Myxema of humerus, coronary occlusion
Flatt, Stephen	70	June 2	Independence	Angina pectoris
Longenecker, Geo. W.	67	June 10	Paola	Splenome-dullary leukemia
Gibson, Charles M.	62	June 15	Pittsburg	Carcinoma of caecum
Westbrook, Paul Arthur	37	Aug. 6	Columbus	Auto accident train collision
Updegrove, William H.	64	Aug. 19	Pittsburg	Carcinoma head of pancreas
Darlington, John W.	88	Aug 21	Valley Falls	Caner of rectum
Fast, William Kirk	53	Aug. 31	Atchison	Coronary



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Stiles, Raymond C., Capt. Medical Corps U.S. Army	30	Sept. 3	Kansas City	Coronary thrombosis Accident in airplane in active service
McKnight, Geo. Campbell	76	Sept. 8	Hiawatha	Coronary thrombosis
Dodds, Andrew J.	85	Sept. 8	Pittsburg	Valvular insufficiency
Wycoff, Chas. Bertram	59	Sept. 9	Jetmore	Diabetis mellitis
Johnson, Jasper D.	67	Sept. 11	Alton	Coronary occlusion
Wickersham, Enoc C.	86	Sept. 18	Independence	Diabetis mellitis
Johnson, John Wesley	78	Sept. 25	Inman	Cerebral arterio, sclerosis, myo
Gray, Arthur D.	56	Sept. 30	Topeka	Acute myocardial failure
Anderson, Arthur J.	79	Oct. 8	Lawrence	Adenocarcimoma of rectum
McDonald, Smith Forrest	66	Nov. 3	Severy	Chronic myocarditis, Pick's disease
Parrish, Merle G.	40	Nov. 8	Kansas City	Coronary thrombosis
Taggart, Henry H.	68	Nov. 9	Wichita	Mitral insufficiency and stenosis
Gilley, Henry W.	92	Nov. 18	Ottawa	Fractured hip
Matassarin, Leon	64	Dec. 6	Leavenworth	Coronary occlusion
Quantius, Leland F.	66	Dec. 7	McPherson	Coronary embolism
Porter, Geo. Franklin	66	Dec. 7	Centerville	Unknown
Cabbell, Herbert G.	55	Jan. 13	Lawrence	Valvular heart disease
Weidling, Walter H.	55	Jan. 16	Topeka	Coronary thrombosis
Shelly, Solomon Thos.	87	Jan. 17	Mulvane	
Stillman, Charles C.	70	Jan. 28	Morganville	Coronary occlusion
Speirs, Geo. O.	67	Jan. 28	Spearville	Coronary occlusion, chr. cardio-vascular disease
Montgomery, J. Carroll	68	Feb. 2	Topeka	Cerebral arterio-sclerosis, chronic asthma
Longenecker, Oscar M.	76	Feb. 26	Kansas City	Occlusion of the coronary arteries
Carter, William Henry	65	Feb. 13	Wichita	Coronary occlusion, arterio-sclerosis
Boyce, Shirley Francis	47	Feb. 17	Hugoton	Chirrosis of liver, chronic nephritis

The following is the report submitted by J. B. Ungles, M.D., Chairman of the Committee on Pharmacy:

TO: THE HOUSE OF DELEGATES:

I wish to report that in as much as there was no urgent business to come before the Committee no meetings were held during the year. All members of the Committee have been notified and have been requested to be present at the annual meeting of The Kansas Medical Society, to be held in Topeka on May 8th and 9th. At this time it is my hope and desire that we may take care of any business or problems necessary which are pertinent, with reference to this Committee.

The following is the report submitted by Warren F. Bernstorf, M.D., Chairman of the Committee on Plasma:

TO: THE HOUSE OF DELEGATES

A meeting of the Committee on Plasma was held at the Hotel Jayhawk on Sunday, July 12, 1942, with a good attendance. At the time it was decided that some arrangement should be made if possible to interest the Kansas State Board of Health in the purchase of equipment for the manufacturing and distribution of dried plasma in order that plasma might be more widely distributed in the State at much lower cost.

Several conferences were had with different members of the State Board of Health, but due to the increased demands upon their time, and also because of the lack of funds, no definite decision was arrived at. In the meantime, the sedimentation method for the preparation of plasma was brought out and widely advertised. This, of course, relieved the situation materially as far as the supply of plasma in smaller communities is concerned. Since that time, there have been several courses and plasma collecting demonstrations for technicians in the State, at which about thirty-one different hospitals have had at least one technician in attendance. These demonstrations have been limited mostly to the sedimentation method of making plasma and the lost cost of equipment has been stressed. It is possible now to have the entire cost of equipment for as little as $25.00, the above outlay being sufficient for making the first twelve doses, with an estimated cost of about $2.00 per dose thereafter.

The Committee feels that more publicity should be given to the methods of making plasms, with particular emphasis upon the sedimentation method because of the ease of preparation by this method, and that more publicity should probably be given to the beneficial effect of plasma, and encouragement of its use more widely. The Committee also feels that when and if the next State meeting takes place that an exhibit on plasma should be part of the scientific exhibits. The Committee also feels that a survey of the location and amounts of plasma in the State should be made and this should be forwarded to the Headquarters of the Seventh Area Office of the Office of Civilian Defense.

The following is the report submitted by George E. Paine, M.D., Chairman of the Committee on Public Health and Education:

TO: THE HOUSE OF DELEGATES:

Since the Committee on Public Health and Education did not hold a meeting this past year, due to circumstances beyond my control, I have no report to be made at this time.

The following is the report submitted by Edgar C. Duncan, M.D., Chairman of the Committee on Public Policy:

TO: THE HOUSE OF DELEGATES

Our Committee did what it could to help the officers of our State Society and others. I think no comment on the Legislative situation during the past year is necessary; all credit is due Drs. Tihen, Lattimore and Loveland.

The following is the report submitted by Ralph I Canuteson, M.D., Chairman of the Committee on Scientific Work:

TO: THE HOUSE OF DELEGATES:

The work of the Committee on Scientific Work was automatically curtailed by the substitution of an administrative meeting for the annual scientific meeting.

September 26, 1942, this Committee met with other



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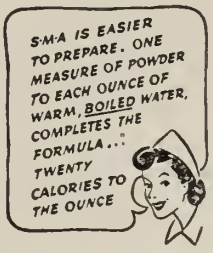
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representatives from the Society, the State Board of Health, the University of Kansas, to discuss the question of broader development of opportunities for post graduate studies for Kansas physicians. Our Committee presented a report on the status of post graduate study in other states. The conclusions from this meeting were that:

1. A balanced course of post graduate study is needed in Kansas.

2. The present war need not interrupt such work; on the contrary, post graduate courses are necessary for the physicians returning to practice, for the limited practitioners who must branch out into less specialized fields, and for physicians who now have less time to get away to medical centers for formal post graduate courses.

3. The agencies now engaged in providing post graduate courses can function to better advantage if there is complete correlation of the various agencies.

4. Kansas physicians should be sounded out as to their wishes in the re-organization of post graduate instruction.

In conformity with these conclusions, it was decided to appoint a smaller active committee to carry on the subsequent work of surveying the field and planning courses. On January 1, 1943 our Committee submitted to Dr. Henry N. Tihen, a second report which recommended, in addition to the gist of the above report, that a committee be set up to act as an advisory group. Membership of this committee would be a representative from:

1. The Kansas Medical Society.
2. The University of Kansas (representing the School of Medicine.)
3. The State Board of Health.

Actual administration of the post graduate studies should be delegated to a suitably trained and qualified man chosen by the Advisory Committee, and who could, preferably, devote full time to the project.

The Committee recommended for representatives from The Kansas Medical Society, a man chosen by the Council, for representative from the University of Kansas, Chancellor Deane W. Malott, and for representative from the Board of Health, Dr. F. C. Beelman.

On January 17, 1943 this report was submitted to the Council. The Council selected Dr. Philip W. Morgan as its representative on the Advisory Council on Post Graduate Study and approved the other two members proposed.

On February 23, 1943 our Committee turned over to Dr. Morgan its file on post graduate studies.

The following is the report submitted by W. K. Hobart, M. D., Chairman of the Committee on Stormont Medical Library:

TO: THE HOUSE OF DELEGATES:

The Committee appointed from The Kansas Medical Society to direct the affairs of the Stormont Medical Library has held no meetings during the past year. All of the business has been under the direction of Miss Louise McNeal, the State Librarian and Mrs. Mateel Todd, Business Manager of the Journal. The following is a condensed report furnished by Miss McNeal and Mrs. Todd:

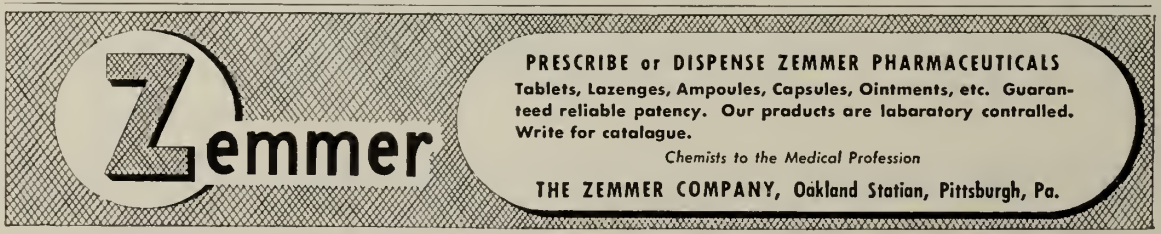
In 1889 Mrs. Jane C. Stormont, widow of Dr. David W. Stormont, presented to the State of Kansas the sum of $5,000.00 for the purpose of establishing a medical library for the use of the medical profession, which would be known as "The Stormont Medical Library". No part of the principal of this gift was to be used but the interest and accumulation were to be expended in the purchase of books, charts and magazines relating to medicine and surgery. No State funds have ever been appropriated for the library and since the income only can be used the lowering of interest rates on bonds has materially reduced the income from the money in the last few years. It has seemed advisable to spend most of the income received for periodicals and a fairly good file of past and current periodicals is available. Gifts, especially from the Journal of The Kansas Medical Society (in review books) have helped greatly in keeping up-to-date books and a variety of periodicals on the shelves. In order to augment the collection, the library has also made a considerable use of inter-library loan service.

The law under which the gift from Mrs. Stormont was accepted provides that a Committee chosen from The Kansas Medical Society shall aid in the selection of material for the library. This law also provides that the library shall constitute a part of the State Library and shall be kept and maintained with that library and shall be forever free for the people of Kansas and particularly for the medical profession.

Because of the crowded condition of the State Library, the present quarters of the Stormont collection are not easy of access nor in any way adequate. It is hoped that some way may be found in the near future to remedy this situation. It is also suggested that if the medical library is to continue to be of practical service, it might be well to try to secure some appropriation from the State to provide additional support.

The financial statement in full for 1941, 1942 and to March 31st 1943 was included in Miss McNeals report and can be examined if any member so desires. The following is the miscellaneous report also included:

Number of medical periodicals received:	
By paid subscription	20
By gift subscription	9
Total	29
Books added to collection	
Gifts from Journal of The Kansas Medical Society	
Spring, 1941	21 Volumes
May, 1942	19 Volumes
August, 1942	13 Volumes
	53 Volumes
Added from other sources	
1941	48 Volumes
1942	70 Volumes



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BOOKS ADDED TO THE STORMONT MEDICAL LIBRARY COLLECTION

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Allen, Paul W. and others—Microbes Which Help or Destroy Us.

American College of Surgeons—1942-3 Yearbook.

American Medical Association—Directory.

American Medical Association—Council on Pharmacy and Chemistry, Annual Report.

American Medical Association—Council on Pharmacy and Chemistry, New and Nonofficial Remedies.

American Medical Association—Hospital Service in the United States.

American Medical Association—Quarterly Cumulative Index, 5 Volumes.

American Public Health Assn.—Diagnostic Procedures and Reagents.

Annual Review of Biological Chemistry, volues 9, 10 and 11.

Barborka, C. J.—Treatment by Diet.

Bauer, W. W. and Hull, T. G.—Health Education of the Public.

Bell, E. T., Editor—Pathology.

Bing, Robert—Textbook of Nervous Diseases.

Blood Transfusion Association—Report.

Brahdy, Leopold and Kahn, S.—Trauma and Disease.

Bridges, M. A. and Mattice, M. R.—Food and Beverage Analyses.

Brown, J. F.—Psychodynamics of Abnormal Behavior.

Carnegie Institution of Washington, Contribution to Embryology, pub. 525.

Chadwick, H. D. and Pope, A. S.—Modern Attack on Tuberculosis.

Clapesattle, Helen—The Doctor's Mayo.

Cohen, Abraham—Acetophenetidin.

Comroe, B. I.—Arthritis.

Drinker, C. K.—Lymphatic System.

Dunham, G. C.—Military Preventive Medicine.

Feder, J. M.—Medical Laboratory Technician.

George Washington University, School of Medicine—Post Graduate Course in Aviation Ophthalmology and Aviation Medicine.

Gifford, S. R.—Handbook, Ocular Therapeutics.

Haden, R. L.—Principle of Hematology.

Haden, R. L.—Principle of Hematology, second edition.

Henry Phipps Inst. (University of Pennsylvania) 29th Report.

Hull, Wright E.—Medical Nursing.

Imperatori, C. J. and Burman, H. J.—Diseases of the Nose and Throat.

Jensen, D. MacL.—Sociology and Social Problems.

Joslin, E. P.—A Diabetic Manual.

Kahn, Samuel—Psychological and Neurological Definitions and the Unconscious.

Kansas WPA—Lamps on the Prarie.

Karnosh, L. J.—Psychiatry for Nurses.

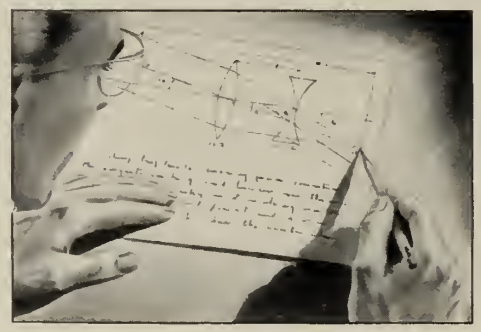
Kilduffe, R. A.—The Blood Bank.

Kovacs, Richard—Physical Theorapy for Nurses.

London, L. S.—Mental Therapy, v. 1 and v. 2.

Long, W. B. and Goldberg, J. A.—Handbook on Social Hygiene.

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Massengill, S. E.—Sketch of Medicine and Pharmacy.

Matheson Commission—Epidemic Encephalitis, Rept. of Survey by Commission.

Mayo Clinic—Collected Papers, volumes 32 and 33.

Meakins, J. C.—Practice of Medicine.

Medical Clinics of North America—15 volumes.

Moodie, William—The Doctor and the Difficult Cild.

Moore, Merrill—Treatment of Alcoholism.

Moore, Raymond and Gray—Drugs and Mental Disease.

Muncie, Wendell—Psychobiology and Psychiatry.

National Foundation of Infantile Paralysis—Collected Reprints of N.F.I.P., 2 vol.

National Foundation of Infantile Paralysis—Infantile Paralysis.

New International Clinics—3 volumes.

New York Academy of Medicine—March of Medicine.

Niemoeller, A. F.—Complete Guide for the Deafened.

Niemoeller, A. F.—Superfluous Hair and Its Removal.

Niemoeller, A. F.—Handbook of Hearing Aids.

Norlin, E. E. and Donaldson, B. M.—Everyday Nursing for the Everyday House.

Perkins, W. H.—Cause and Prevention of Disease.

Raney, R. B. and Shands, A. R.—Prevention of Deformity in Childhood.

Resnick, Louis—Eye Hazards in Industry.

Rigler, L. G.—Outline of Roentgen Diagnosis.

Schaub, I. G. and Foley, M. K.—Methods for Diagnostic Bacteriology.

Siegel, Morris—Population, Race and Eugenics.

Societatis Pathological Japanicae—Translations of volumes 27, 28, 29 and 30.

Spaeth, E. B.—Principles and Practices of Ophthalmic Surgery.

Steinbrocker, Otto—Arthritis in Modern Practice.

Stimson, P.M.—Common Contagious Disease.

Surgical Clinics of North America, 12 volumes.

Thewlis, M. W.—Care of the Aged.

Titus, Paul—Directory of Medical Specialists.

Van Blarcom, C. C.—Getting Ready to Be a Mother.

War Department, Army Medical Library—Index, Catalog of Library.

Wilder, R. M.—Clinical Diabetes Mellitus and Hyperinsulinism.

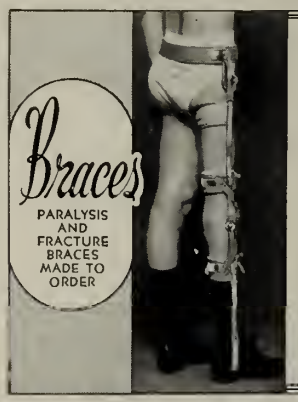
Yearbook of General Medicine, 1939.

Yearbook of General Therapeutics, 1939 and 1940.

Yearbook of Industrial and Orthopedic Surgery, 1940.

Yearbook of Obstetrics and Gynecology, 1939.

Yearbook of Pathology and Immunology, 1940.


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Yearbook of Pediatrics, 1939.
Yearbook of Public Health, 1940.
Yearbook of Surgery, 1939.

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Periodicals received.
American Journal of Diseases of Children.
American Journal of Medical Science.
American Journal of Public Health.
American Journal of Surgery.
*Annals of Otology, Rhinology and Larynology.
Annals of Surgery.
Archives of Internal Medicine.
Archives of Ophthamology.
Archives of Otolaryngology.
Archives of Pathology.
Archives of Pediatrics.
Archives of Surgery.
*Cleveland Clinical Quarterly.
*Current Medical Digest.
Endocrinology.
Journal of American Medical Association.
Journal of Experimental Medicine.
Journal of Laboratory and Clinical Medicine.
*Journal of Kansas Medical Society.
Lancet, The.
*Medical Economics.
Medical Record.
*Modern Medicine.
*Journal of the Missouri State Medical Association.
*Quarterly Bulletin Sea View Hospital.
Quarterly Cumulative Index Medicus.
Surgery, Gynecology and Obstetrics.
*Texas State Journal of Medicine.
War Medicine.
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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

MEDICAL ASSISTANTS ANNUAL MEETING

Plans for the annual meeting of the Kansas Medical Assistants Society, which is to be held in Topeka on May 16, are going forward according to word received following an executive board meeting held recently. The meeting will be held at the new home of the Shawnee County Medical Assistants Society in the Victory Life Insurance Building at Eighth and Van Buren Streets (directly north of the State House). Registration will start at 9:00 a. m. and a program will immediately follow the registration. Luncheon will be held at the Hotel Kansan and the election of the new State officers for the society and other important business will follow the luncheon.

Letters are being forwarded to members of the society and your letter will include a card which must be returned to Grace Brooks, Registration Chairman as early as possible, for reservations for the luncheon.

The hotel facilities in Topeka are somewhat crowded and more so over the week-ends. It will, therefore, be necessary for anyone wishing rooms to make reservations as early as possible.

KANSAS MEDICAL ASSISTANTS SOCIETY AMENDMENT TO CONSTITUTION

An amendment to the original Constitution and By-laws of the Kansas Medical Assistants Society which was presented at the 1942 state meeting in Wichita will be voted on at the 1943 annual meeting to be held in Topeka on Sunday, May 16th. The following is the amendment:

"Chapter 3, Section 3: That the annual nomination and election of State officers shall be held at a meeting immediately following the luncheon of the main day of the meeting."

MEDICAL ASSISTANTS MEETINGS

The Cowley County Medical Assistants Society held a meeting in Winfield on March 18 for the election of officers. Miss Mary Nicholson was elected as the President succeeding Miss Bea Parker; Mrs. Ethel Mudd as Vice-President succeeding Miss Irma Dickey; and Miss Mary Edith Bacher as Secretary-Treasurer succeeding Mrs. Hazel Holley. Mrs. Marjorie Story, Cowley County Public Health Nurse was a guest speaker at the meeting and gave an outline of her work in the county.

The Shawnee County Medical Assistants Society held a meeting in Topeka on April 5. Miss Dorothy King spoke on "Personal Hygiene".

The Wyandotte County Medical Assistants Club held its March 23 meeting at the Chamber of Commerce rooms in Kansas City. Dr. L. G. Allen of Kansas City showed a movie entitled "A Trip to Hudson Bay."

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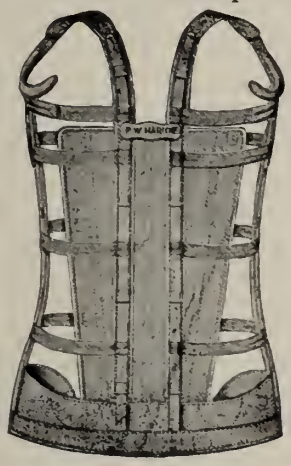
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AUXILIARY

PRESIDENT'S MESSAGE

In reviewing the past and contemplating the future of auxiliary work today, I call to mind a paragraph in the last issue of the Bulletin, which was a reprint from the California Medical Auxiliary Courier, as follows:

"Today men and women in the armed forces, and the civilians at home, are fighting and working to defend and preserve 'Our way of life'."

Our doctors of medicine have been fighting "for Our way of life" since 1540 A. D., at which date in history the early schools of medicine arose.

"Our way of life"; preventive medicine, sanitation, good housing, prenatal care, nutrition; and we could go on and on.

All energy today is directed toward VICTORY over our



MRS. C. OMER WEST

vicious foes in war. As members of an Auxiliary to the profession of Doctor of Medicine we may think of victory in connection with that profession. Our doctors of medicine have been victors in their war on disease that threatens mankind, and many have given their lives in attending their professional duties, as for instance in contagious diseases. Victory is their in insulin, in the treatment of diabetes, in the use of sulpha drugs, and in the thousand and one modalities of twentieth century medicine, for the prevention, control and treatment of human disability.

May I urge you to exercise your privilege of membership in an Auxiliary to this noble profession."

This is only one more reason why no one should consider dropping her membership in the Auxiliary.

And now, looking back over the past year, I want to express my gratitude to the Board and to each and every member of the Auxiliary for their inspiration and help. While we did not accomplish all we had wished to, perhaps it is not altogether regrettable. If our goal were never higher than our accomplishments our ambitions would soon die.

I hope each of you who are Delegates to the State meeting will make an special effort to attend. I shall look forward to seeing you.

Sincerely

Mrs. C. Omer West.

AUXILIARY NEWS

The Women's Auxiliary to the Central Kansas Medical Society held a meeting on April 8 at the home of Dr. and Mrs. P. S. Brady in Hays. Mrs. C. Omer West of Kansas City, State Auxiliary President was the guest of honor. The Auxiliary members held a business meeting which was followed by a joint dinner with the members of the Central Kansas Medical Society.

The April luncheon meeting of the Auxiliary to the Sedgwick County Medical Society was held in Wichita. At the March 8th luncheon meeting of the society Mrs. C. Omer West, State President of the Auxiliary of Kansas City was a guest. Other out of town guests included Mrs. Frank Coffey of Hays, Mrs. H. L. Regier of Kansas City, and Mrs. L. B. Gloyne of Kansas City.

AUXILIARY STATE MEETING

The annual meeting of the Women's Auxiliary to The Kansas Medical Society will be held in Topeka on May 8 and 9.

Mrs. J. L. Lattimore of Topeka is in charge of arrangements for the meeting. Tentative plans schedule the first meeting for Saturday, May 8 at 7:00 p. m. The main social event of the meeting will be a breakfast on Sunday, May 9 at the Hotel Kansan. It will be necessary for all women attending the meeting to make hotel reservations as early as possible, due to the war situation and the probable shortage of available rooms in Topeka.

Reports of officers, councilors, and committee chairmen are being published and will be read at the meeting.

WORKERS

When you work upon committees
For societies or cities,
You will find a very few do all the work,
While the others do the talking,
And are critical or balking,
And the vast majority just loaf or shirk.

So I hand a wreath of laurel
To the man who does not quarrel
With the job he finds assigned to him to do,
Who will work on his committee
With no long and loud self pity—
When he says he'll do a thing he sees it through.—Illinois Medical Journal.

Nutritional deficiency, directly or indirectly, have disqualified about one man in seven for military service.—Bulletin of the National Tuberculosis Association.

Woman graduates made up 5.4 per cent of the total output of United States medical schools in the past year. Recent estimates place the total of woman physicians in this country at 7,500.—Medical Economics.

The Journal Of
THE KANSAS MEDICAL SOCIETY
Owned and Published by The Kansas Medical Society

Volume XLIV MAY, 1943 Number 5

THE PRESIDENT'S ADDRESS

Henry N. Tihen, M.D.
Wichita, Kansas

The time is at hand for me to make the presidential report upon the state of affairs of our Society. An indication of senescence is the tendency to look backward upon the work accomplished; a sign of youth is the looking forward on the work lying ahead. Since The Kansas Medical Society has the spirit of youthful vitality and forward vision, I will not devote too much time in reviewing the work done or undone as that is a matter of record but will try to look forward into the work and accomplishments—and perhaps tribulations—that lie ahead.

GENERAL OUTLOOK

Medicine is today in the center of a stream of strong and diverse currents tending to force us in this or that direction. The outcome is entirely uncertain. Much of the future of medicine is being, and will continue to be, decided in the legislative halls of Congress and in the various state legislatures, and these legislative bodies in turn are partially influenced by general public opinion concerning the position of medicine. Our national organization has so far failed severely in any understanding of the nature of leadership required to furnish the public and our legislative leaders with the information and the contacts that would give the medical profeession itself the influence it should have in charting medical policies. Unless a more realistic conception of this situation is adopted by the leaders of the American Medical Association, American medicine will continue to exercise much less than its due influence in guiding the destiny of medical affairs.

THE CENTRAL OFFICE

As you all know, our Executive Secretary, Clarence Munns, out of a sense of duty and patriotism beyond the mere letter of the law, entered active military service last September. We have missed his capable help and experience. After careful study by a special committee, Robert Brooks was selected to fill this position. His many good qualities have been utilized during a strenuous legislative year and the central office, with Mr. Brooks and its present personnel, Mrs. Foster and Mrs. Barney is well staffed to give our Society the help that it needs in carrying on its many activities.

THE JOURNAL

The Journal of our Society has continued to be an outstanding state medical publication due largely to the unfailing efforts of its editor, Dr. W. M. Mills. We owe a debt of deep gratitude for this important work done in behalf of Kansas medicine and The Kansas Medical Society. With the able assistance of Mrs. Todd, he has maintained the high quality of our State publication.

BOARD OF HEALTH

Under the leadership of an able group of physicians as members of the State Board of Health, I wish to report the friendly cooperation of the Board of Health with our Society in all matters. Dr. Floyd Beelman has been doing an outstanding work as Secretary of the Board of Health and I wish to acknowledge his interest in and cooperation with the medical profession of Kansas. The friendly cooperation between the medical profession and the Board of Health is highly desirable in the interests of both the profession and the health work.

COMMITTEE WORK

It was realized that the war activities would curtail the amount of much committee work. It has been left to the judgment of each committee chairman as to the necessary work for his committee under these conditions.Three new committees were appointed by me last year—namely, the Committee on Plasma, Appendicitis and Conservation of Hearing. I believe that the problems and opportunities ahead in each of these three fields would justify their continuance as permanent committees. Furthermore, as a general policy, I feel that under normal conditions the greater the number of our physicians working and serving on committees, the stronger our Society will be.

Kansas as a State is passing out of its pioneer period and it is highly desirable that the material on the early medical history of Kansas be assembled and preserved for a publication of the history of Kan-

sas medicine. I had hoped that our Historical Committee this year might begin this project but war conditions have interfered. I would urge upon the Society the importance of collecting this material as soon as possible while there is still some first-hand information available from both medical and lay pioneers.

POST GRADUATE MEDICAL PLANS

At my request early in the year our Scientific Work Committee made a study of the subject of post-graduate medical education in many states with the idea of developing a coordinated medical teaching program for Kansas. This committee made an extensive survey of the problem and turned in an excellent report, suggesting the formation of a permanent committee composed of the Chancellor of the University of Kansas, the Secretary of the Board of Health and an appointee for a three-year term from the Kansas Medical Society. This report was approved by our Council, and Dr. Philip Morgan of Emporia was appointed as the Society representative on this committee. This committee is now functioning and is going ahead with study and plans for the development in Kansas of an all-around program of post-graduate instruction that should advantageously serve all of us.

LEGISLATION

Only by actual contact with some of the problems involved can one become cognizant of the many forces that react on our legislative position. Starting with very little legislative influence in 1934, the Kansas medical profession has gradually gained increasing recognition from year to year. We must expect to continuously maintain our interest in State legislation, since much of the future of medicine and the quality of medical standards in Kansas will be determined by legislative acts. It is not only because of our own interest but because of the necessity of guarding the medical welfare of the public that we must keep an active interest in progressive medical legislation.

With the background of the experience of the recent meeting of the legislature, I have the following suggestions to offer:

1. That our legislative program must be a continuous process of interest and study, not a sporadic interest every two years when the Legislature convenes. Our officers and Council and committees must consider what laws are desirable in the maintenance and development of adequate medical standards in this State. Sound policies cannot be developed on the spur of the moment when the Legislature is in session. A well thought-out medical program should be constantly under study so that sound and proper bills may be ready for presentation on any matters pertaining to the medical welfare of the public.

2. Sound medical and health legislation will be immeasurably facilitated by having two or three doctors of medicine in the House and one or two in the Senate. We have no medical members in the House at present. One of our most urgent needs is the election of at least two sound, able physicians to the House. Every county society, as well as our State officers, should give this matter consideration at once.

3. Likewise, every doctor in the State and every county society should maintain a constant interest in the reaction of their State Representatives and State Senators to the problems involving medical health and medical standards. A great deal can be accomplished if each county medical society will keep in constant touch with the State Legislators from their counties.

4. During the meeting of the Legislature your State officers and central office make every effort to contact the members of the Legislature in order to acquaint them with the medical side of medical and health measures. This has a tendency to promote sound medical legislation; however, there are a number of Legislators who attend the Legislature and bring their wives and families to Topeka with them. It has been difficult for your officers to make as close an acquaintanceship with this group as is desired because of difficulties of entertainment. It is my strong belief that the Shawnee County Medical Society could make a valuable contribution to our legislative efforts by cultivating the friendship of this group of Legislators and their wives in small groups in their homes. I hope that the officers of the Shawnee County Society will develop a strong legislative committee that will arrange for the details of this contribution to the legislative efforts of The Kansas Medical Society.

5. Each doctor should maintain an interest in the welfare of his own political party in an effort to secure the best political leadership for our State and in order that medicine may have its due consideration from the leaders of both parties. However, I am safe in saying that in case of conflict between party allegiance and the welfare of medicine in any individual case, the medical profession will stand united in opposition to any candidate whose election would be detrimental to the medical welfare of the State.

PUBLIC EDUCATION

The tremendous field of public education on medical matters has hardly been scratched. The public in general is entirely unaware of the difference in medical standards of the various groups following the healing art. They likewise are not well enough informed in many fields of health matters so that anti-vivisectionists, anti-vaccinationists, and the many other cults can continue to exist. Likewise, unsound

plans of medical care may be promoted by various organizations or groups or individuals who have no real conception of the basic facts of medical care. The medical profession must assume responsibility for the education of the public in medical matters and medical policies; and if we will but take the time to do this piece of work, it will develop a strong force of public opinion back of the ideals of medicine and back of the medical profession.

THE CULTIST PROBLEM

Since medicine began to have a scientific foundation, the profession has had to face the problem of the cults. With the great development of scientific methods in medicine the cult problem becomes much more important because of the ever-increasing improvement in the quality of medical and surgical care that may be rendered by the well-trained doctor of medicine. It, therefore, becomes a matter of life and death for many people if these high medical standards of the regular profession are not maintained. The crux of the situation lies in the fact that the cultist holds himself out as a person capably trained to look after a sick patient, when as a matter of fact, none of his schools has ever maintained any adequate standards for the training of their students in medicine and surgery. Furthermore, in most cases the cultist is not primarily interested in practicing his cult but in using his cult title of doctor as a pretense for practicing as much medicine and surgery as possible. The American Medical Association has exhibited no real leadership in opposing the extension of cultists.

The cultists gain every-increasing recognition in Federal Legislation, and the medical profession of each state has had to meet its legislative difficulties single-handed from state to state, with the result that the cultists have entrenched themselves in various states in their legislation to the point that the standards of medical care in many states have been seriously lowered. Following this same road to legislative recognition to which their training does not entitle them, are the osteopaths, the chiropractors and naturopaths.

It is not at all inconceivable, if our nation association had given as much consideration as it should to this problem, that long ago some form of state laws could have been enacted enforcing some type of standards on any school that sets itself up as a training center for any of the healing arts. Whenever any real standards are enforced for their schools, these cult schools will disappear and with them, organized cultists.

The enforcement of the medical practice laws of our State is the duty of the State Board of Medical Examination and Licensure. This Board has always indicated its willingness to cooperate with the medical profession of Kansas. The medical laws of Kansas are plain in denying to the cultists the right to practice medicine and surgery. These laws are being flagrantly violated on every hand and I am convinced that moderation in their enforcement has only weakened the position of medicine. I feel that it is entirely within the province of the members of The Kansas Medical Society to ask for enforcement of medical practice laws. Evidence of these violations is so profuse that any real effort to obtain this evidence will quickly yield results and I feel that we should expect the State Board of Examination and Licensure to proceed immediately toward active enforcement of these laws.

WAR PARTICIPATION

The medical profession of Kansas has met its war obligations promptly and we will continue to promptly fill voluntarily any quota assigned to us for the armed forces.

At present we have fulfilled all requests made of us, and Kansas has no further quota for 1943 as of the present date. What future calls there may be we do not know.

Under the leadership of Dr. Forrest Loveland as State Procurement Chairman, Kansas is recognized in national procurement headquarters as having done an excellent work so far in medical procurement. As the situation levels off it is becoming apparent that the medical care of the civil population has so far been satisfactorily guarded in Kansas. The rather marked changes in population figures from various areas in the State should stabilize fairly well within the next few months, making somewhat easier the judgment on the number of doctors necessary for civilian care. This will also make easier the further selection of physicians for the armed forces as it becomes necessary. The public is holding the medical profession responsible to a considerable degree for adequate medical care in every community. If this care is not maintained, the position of medicine in the State will suffer. It becomes absolutely necessary for the doctors in every county in this State to strain themselves to the utmost if necessary to maintain this care. We know the doctors from Kansas on the war front in active military service will do their part. The doctors remaining at home in the care of the civil population on the home front must make whatever sacrifices are necessary or whatever plans are desirable to maintain the civil medical care in their communities and in their counties.

CONCLUSION

I wish again to express to the members of our Society my appreciation for the honor of being your President during this past year. In addition, I wish

to express my thanks to the many members who have given freely of their time, their counsel, and their aid in our Society work during the past year. I would commend to all of you the thought that only as you give of yourself will our Society, and with it, medicine progress.

INFECTIOUS MONONUCLEOSIS FROM A CLINICAL STANDPOINT

Hughes W. Day, M.D.

Kansas City, Kansas

Undiagnosed fevers and illnesses constitute a serious problem to the clinician. In the last ten years, infectious mononucleosis has become a definite clinical entity and one which is now easily diagnosed, providing the attending physician remembers the possibility of the disease, and takes steps to definitely establish its presence.

The history of the disease starts in 1881, when Emil Pfeiffer[1] gave the first description of what we now know as infectious mononucleosis under the title of "Drusenfiber." He wrote that children are chiefly affected, with fever, swelling of the cervical glands which do not suppurate, and an enlargement of the liver and spleen. In 1901 Burns[2] first called attention to the blood picture and noted the changes in the differential count, in addition to the leukocytosis which Gourichon[3] had reported in 1893. He found that "Small mononuclear elements of the blood seem to be the ones principally increased."

Infectious mononucleosis is chiefly seen in children and young adults. Bernstein[4], who wrote an excellent review of the disease, states that infectious mononucleosis is seen in males more than females in a ratio of three to two. The disease usually starts with a sore throat of varying intensity. Inspection of the throat frequently reveals a markedly inflamed pharynx and tonsils and at times the appearance resembles the throat in scarlet fever. Frequently a white membrane is present on the tonsils and gums and has the appearance of Vincent's angina. Smears from such a patient's gums will show numerous organisms typical of this disease. It is reported that about thirty to forty per cent of the patients with infectious mononucleosis show a Vincent's infection also, and because of this fact, it is advisable to run a Paul-Bunnell test and differential blood smears on all patients with Vincent's angina.

A generalized non-suppurative lymph-adenopathy is the rule in this disease. The patient frequently complains of pain in the neck, chest, and abdomen, which is due to the lymph-adenopathy. The spleen and liver may be enlarged. At times jaundice is present with hemorrhagic tendencies and occasionally nose bleed occurs. The patient is generally constipated with diarrhea being rare, although at times it may be present. Occasionally one may see a patient with involvement of the central nervous system with either meningitis or encephalitis. Bernstein[4] speaks of a case in which a lumbar puncture revealed a cell count of 1,000, nearly all monocytes.

There is present in about twenty-five per cent of the patients an edema of the eyelids and face. At times the edema is quite marked and produces considerable discomfort to the patient. Intra-venous calcium gluconate helps to relieve this.

The rash that at times is present in infectious mononucleosis is very interesting. It usually begins as a maculopapular eruption on about the fourth to the seventh day of illness, and at times is purpuric in character. The rash may coalesce and form a scarlet eruption which has the appearance of the rash in scarlet fever. There is no blanching by the Schultze-Carlton test. Following the rash, desquamation generally occurs.

In the majority of cases, the white blood count will vary from 8,000 to 25,000, however, a leukopenia is sometimes seen early. The differential count of infectious mononucleosis is the striking and characteristic feature of the disease. There is a constant increase in the mononuclear cells, both monocytes and lymphocytes, with a definite increase of lymphocytes up to as high as sixty to eighty per cent sometime during the illness. The disease could be called, more accurately, therefore, infectious lymphonucleosis. However, these cells are not mature lymphocytes and many times as high as thirty per cent undifferentiated cells are present. Downey and McKinlay in 1923 described these cells as three types of immature lymphocytes which may predominate the blood picture. The following description is taken from Atlas of Hematology by Kracke and Garver[5].

The Type I cell is not excessively large as compared to the normal lymphocyte but the nucleus shows a marked lobulation with chromatin in the form of a coarse network of heavy strands and masses which are not sharply separated from the parachromatin. The cytoplasm is quite basophilic. The spongioplasm is dark blue, finely granular, with a pale yellow background of hyaloplasm. The cytoplasm has a vacuolated appearance. Azurophil granules are found in the hyaloplasm.

The Type II cell resembles a plasma cell. The chromation strands are very coarse with masses of chromatin among them. There are fewer vacuoles in the cytoplasm and it is less basophilic. Therefore, there

is a smoother appearance of the spongioplasm and this cell does not have the foamy, spongy effect of Type I.

Type III cell has a more leukemic appearance. It has a vacuolated, basophilic cytoplasm. The cell is large and the nucleus appears immature. There is more hyaloplasm but the distribution of the spongioplasm is relatively the same. Occasionally one may see a single large vacuole with an azurophil rod within an indentation of the nucleus. This feature has been seen in the cells of an acute leukemia.

It is frequently difficult, therefore, to rule out an early leukemia from the blood smears alone. However, in 1932, Paul and Bunnell[6] developed the heterophile anti-body test which shows a clumping of sheep cells by the patient's serum. This reaction is not seen in leukemia except in a very low titre. Recent injections of horse serum will also produce a very high titre in the patient's serum and, therefore, a titre of 1:100 in the absence of recent horse serum therapy is considered diagnostic of infectious mononucleosis[7]. One is impressed by the fact that the Paul-Bunnell test is positive in high titre early in the patient's illness. This may mean that the incubation period of the disease is longer than the figure given of five to fifteen days.

The etiology of infectious mononucleosis is not known. Several theories have been advanced, among them that listerella monocytogenes or a virus is the infecting organism. The frequent association of mononucleosis and Vincent's angina is interesting, but as yet no real light has appeared to definitely establish the etiological agent.

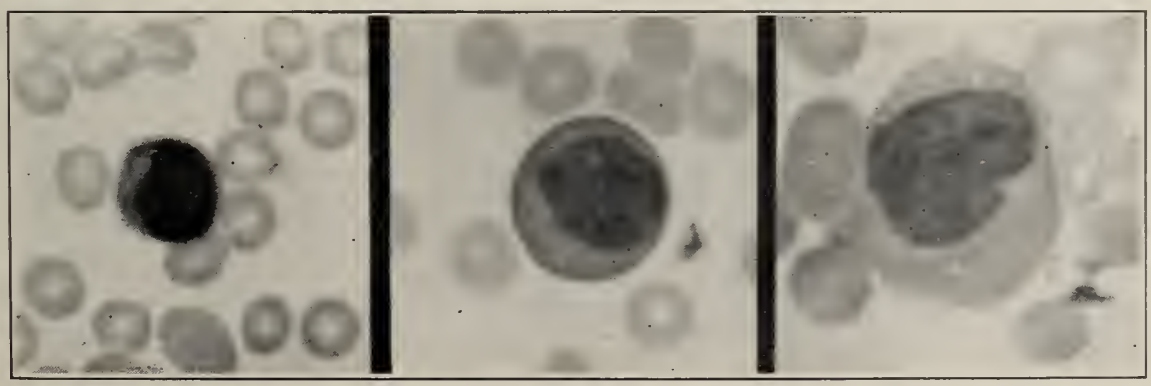
The mortality rate of infectious mononucleosis is very low, being approximately one-half of one per cent. As recovery is almost certain, the treatment of the disease is chiefly supportive and symptomatic. In severely ill patients, small blood transfusions, given daily, are definitely beneficial.

CASE REPORTS

Case I—B. W., a white female, seventeen years of age, was admitted to Providence Hospital, Kansas City, Kansas, (all of the subsequent cases were hospitalized at Providence Hospital) on the service of Dr. Merle Parrish. Her temperature, on entry, was 100.4, with a pulse rate of 125. Her presenting complaints were swollen and tender glands, weakness, chills, sore throat, and joint and muscle pains. The onset of the illness was gradual over the preceding two weeks. She had been well prior to that time. Her physical findings on admittance were a generalized tender lymph-adenopathy, with a tender palpable spleen, two fingers below the left costal margin. Her tonsils were hypertrophied and many small white spots were present on the left tonsil. The heterophile anti-body test on the day of admittance showed agglutination in dilutions up to 1:448. The admitting blood count revealed an anaemia with a hemoglobin of sixty-two per cent. The red blood count was 3,420,000. The leukocytes were 6,050 with twenty-eight per cent polys, twenty-six of which were non-filamented. There were forty-five lymphocytes, twenty per cent monocytes, five per cent myelocytes and two per cent meta-myelocytes. The sedimentation rate fell to twenty-one M. M. in one hour with a corrected rate of .4 and an hematocrit of thirty-six. The Wassermann and Kahn were negative. The patient's temperature rose to 103.8 on the first hospital day, and then gradually dropped, reaching normal on the fourth hospital day.

Case II—T. S., a white male, age thirty-five, a patient of Dr. Lewis Angle, was admitted with a chief complaint of weakness, and pain in the upper left abdomen with tender inguinal nodes. His complaints had been present for two days prior to entering the hospital. His positive physical findings consisted of a generalized lymph-adenopathy with a palpable spleen. He ran no fever during his hospital stay. The admitting blood count revealed a hemo-

Fig. I. Type I cell of infectious mononucleosis. Fig. II. Type II cell of infectious mononucleosis. Fig. III. Type III cell of infectious mononucleosis.



globin of eighty-eight per cent, with a red blood count of 4,310,000. The leukocytes were 12,600 with nineteen per cent polys, ten of which were non-filamented. There were fifty-five per cent lymphocytes, twenty per cent monocytes, and six per cent unidentified cells. The heterophile test was 1:896 on the second hospital day. Wassermann and Kahn were reported negative. The blood chemistry was entirely normal. The patient left the hospital after five days with the spleen being no longer palpable.

Case III—M. M., a white female, eighteen years of age, was admitted on the service of Dr. T. J. Sims, approximately six weeks following the birth of twins. Her presenting complaints were weakness, chills, fever, severe headache and backache, with burning on urination, which had been present for the preceding twenty-four hours. Her positive physical findings were hypertrophied and inflamed tonsils, with numerous tender cervical glands. A catheterized urine specimen showed occasional pus cells and erythrocytes. Her temperature on admittance was 102, and her blood count showed an anaemia with sixty-eight per cent hemoglobin, and 3,520,000 red blood cells. The leukocytes were 7,950 with thirty-three per cent polys, eight of which were non-filamented. The lymphocytes were fifty-six per cent with one per cent monocytes, and nine unidentified cells. Because of the patient's complaints and urinary findings, a diagnosis of pyelitis was considered, but with the peculiar blood picture, a heterophile test was ordered and showed agglutination in dilutions including 1:448. She left the hospital on the fifth day of her clinical illness with no fever or complaints.

Case IV—R. W., a white female, age twenty-seven, was admitted to the hospital after having been ill for five days with fever, pain over both kidney areas, and some burning on urination. The temperature on admittance was 102. Her physical findings were negative except for tenderness over the right and left lumbar areas. A catheterized urine specimen on the day of admittance showed occasional erythrocytes with two to five white blood cells per high power field. The blood count on admittance showed no anaemia, and the leukocyte count was 5,150 with thirty-six per cent polys, twenty-three of which were non-filamented. There were twenty-two lymphocytes, ten per cent monocytes, and thirty-four unidentified cells. Because of the blood picture a heterophile anti-body test was ordered on the second hospital day. It was reported as showing complete agglutination in 1:112, and partial in 1:224. On the patient's third hospital day some glands were felt in the cervical area. The patient developed a sore throat with a palpable spleen twenty-four hours later, at which time the heterophile test showed complete agglutination in dilutions including 1:448. One week later she was temperature free and left the hospital with no complaints except some weakness. When seen at the office nine days later, she had a leukocyte count of 5,000 with thirty-four per cent polys, thirty-three of which were filamented. There were sixty-four per cent mature lymphocytes with two per cent monocytes. Her hemoglobin was seventy-eight with 3,950,000 red cells.

Case V—W. W., a white male, age thirty-four, was admitted to the hospital with a temperature of 100, and complaining of an acute sore throat. He had been ill for two days prior to admittance. Physical examination revealed an acute throat with a white membrane present around the gum margins and over one tonsil. It was associated with marked cervical-adenopathy. Smears from the patient's gums revealed numerous organisms typical of Vincent's infection. His admitting white count showed a leukocytosis of 12,950, with twenty-eight per cent polys, sixteen of which were non-filamented. There were fifty per cent lymphocytes, ten per cent monocytes, and ten unidentified cells. The heterophile anti-body test was positive in agglutination of 1:896 on the fourth hospital day. His sore throat and temperature improved and he was allowed to leave on the seventh hospital day. That evening at home the patient had a hard chill and developed a scarlet rash of a confluent, maculopapular type. He was re-admitted with a temperature of 103, and a pulse rate of 105. He developed a marked edema of the face and orbital tissues, but his urine and blood chemistry remained normal. The rash developed the appearance of scarlet fever, but a Schultze-Carlton test was negative. He gradually improved under daily small blood transfusions, and left on his twenty-ninth hospital day.

SUMMARY

1. The characteristic features of infectious mononucleosis are sore throat, lymph-adenopathy, and a palpable spleen, associated with fever, edema of the face, and occasionally a rash.

2. The blood picture shows a definite increase of the cells of the lymphocytic series, and the diagnosis may be confirmed by the Paul-Bunnell test. It is positive early in the disease. Approximately two or three months elapse before the differential blood count returns to normal.

3. Treatment is symptomatic but small, daily blood transfusions are definitely beneficial in severely ill patients. In our series, all developed a secondary anaemia which lasted approximately two months.

4. Patients with infectious mononucleosis may run a low grade fever for several months and pros-

tration and weakness frequently extend over a long period of time.

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FUNDAMENTALS OF PSYCHIATRY VIII

THE OBJECT-FINDING PHASES OF DEVELOPMENT

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The primitive psychological drives to obtain gratification which are present in every individual at birth, are expressed by various methods (oral, anal, genital) toward specific aims, each of which makes up one of the stages of the psychosexual development of the individual. Using these different methods or modes, the individual consciously directs his interest to "various choices of objects" as a source of obtaining gratification. At first his object choice is a particular part of his body; then his total personality becomes the object; then his choice becomes other people like himself, i.e., those of the same sex, and finally he chooses someone of the opposite sex. As the individual develops in the course of normal growth, he changes the choice of his object through this regular evolution. Again it is desirable to emphasize that this evolution is "development," and is a normal feature of every person's life.

The process of growing up psychologically requires a transition through these four major changes in the type of object from which gratification is derived. We shall see, however, that some individuals never go through the entire evolution, some never want to leave one choice of object from which they have received excess gratification to advance to another. On the other hand, even though the individual grows up he may retain certain methods of obtaining satisfaction from each of these stages and utilize them in the adult stage. This can best be illustrated by examples in the discussion of these four different object choices.

THE AUTO-EROTIC STAGE

During the first year or even two years of life the little child does not differentiate between "I" and "it." From this point of view, this period of life is object-less, and the mother as well as all of the immediate environment is really a part of the child himself. He obtains his gratification from purely mechanical measures and means, and the prohibitions and inhibitions of reality and civilization do not exist. The little child wants to incorporate the world and in normal development he tries to put everything in his mouth. He tries to make everything a part of himself. He gets his gratification from sucking, biting, defecating, urinating, squirming, kicking, jumping, in all of which he makes no real object choice. All these activities concern only himself, and this period is designated as the "autoerotic stage."

THE NARCISSISTIC STAGE

At about the age of two years the child learns to differentiate himself from the world, or rather, the world from himself. From this age on, however, "he" is the important person in the world, and he himself becomes the "object" of his interest. In contrast to the object-less situation in infancy he now begins to differentiate himself from his crib or from his mother, but still fixes his attention upon himself as the object. This period is termed the "narcissistic stage," based on the Greek myth of Narcissus who regarded himself as being more beautiful than anyone else. He literally "fell in love" with himself, and on seeing his image reflected in the water became so desperate when the image did not respond to his call except to echo that he fell into the pool and drowned. In compassion, the gods changed him into a narcissus so that he might always view his image in the water.

The chief characteristic of this age in childhood is the "self-love," the interest which is invested almost entirely in the self. It is during this period of life that the child goes through the "show-off" period; he wants to exhibit himself in every way that he can to create and attract attention. Unless he is abnormally intimidated, his own property and his own interests are all that concern him. This type of behavior when it occurs in an adult is regarded as being selfish, greedy, inconsiderate and self-centered. But in the child of three to six years, it is normal, and an expression of self-love, i.e., "narcissism."

There is a mixing of the sexes throughout this period without any conflict between them. The little boy and girl of six to ten mix with each other without the inferences of being a "sissy" or a "tom-boy" and without the subsequent feeling of embarrassment or shyness which characterizes a later age. It is during this age that the little child independently asserts his own choice of playmates, of play methods and toys.

At the age of three or four years, this "self-love" is at its height, both as to intensity and variety of

expression. But as the child's life begins to expand to include playmates, and school teachers, and as he begins to accept the property rights of others, he must necessarily free some of his interest from himself to invest outside himself. He exchanges it for gratification obtained from others. He learns to give for the advantage of receiving.

This narcissistic stage exists with diminishing intensity throughout life. There is a transitory renewed emphasis upon it at puberty, when again the individual becomes tremendously interested in himself. It is at this period that he begins to pay special attention to his appearance, to his clothes, to his hair dress. It is at this period in puberty when the majority of normal individuals again indulge in the form of "self-love" known as masturbation. This renewed wave of narcissism in puberty usually fades again to an inconspicuous point. Nevertheless, in adult life every individual maintains some degree of narcissism. Sometimes it remains as the chief means of gratification and as such is a pathological state. We see adults who dress in very conspicuous and gaudy clothes as a method of calling attention to themselves. They are exhibitionistic in their manner and their behavior; they have an unbounded belief in their own potentialities and possibilities. They are regarded by everyone else as being conceited and one can see the "self-love" expressed in many, many ways. In such instances the narcissism is to be regarded as pathological.

In contrast to such pathological expressions of narcissism, every normal adult maintains a certain amount of pride, of respect for himself, of interest in himself, but these mild forms of "self-love" do not overshadow or dwarf the amount of interest he is able to invest in objects outside himself as his chief sources of gratification.

THE HOMOSEXUAL STAGE

From about the age of ten years on to and often including early puberty the individual becomes interested in an "object" outside himself, namely, a person of his own sex. The transfer from the narcissistic stage is a simple one, because in a sense he becomes interested in his mirrored image — another person just like himself. This interest in one of the same sex continues to some extent throughout life though with much less intensity than at this period between ten and fifteen years of age.

Homosexual interests are quite normal for every individual at this stage and are well illustrated in the tendency to form gangs, to be chums. It is the age of "crushes" and of hero worship. It is because the individual finds his chief source of interest in persons of the same sex that youth organizations thrive and succeed, such organizations as the Boy Scouts and Girl Scouts, the Girl Reserves, the Hi-Y, the Campfire groups.

This object choice of one of the same sex persists into adult life, sometimes to the exclusion of any interest in the opposite sex. In this latter instance it is to be regarded as pathological, and the ultimate form of gratification is in sexual relations with one of the same sex.

This source of gratification persists, in lessened degree however, in every normal individual and gives rise to the development of social impulses, close friendship, comradeship, "esprit de corps." It contributes to the individual's love for mankind in general. It is not to be presumed that adult organizations limited to one sex are in any sense pathological. Such organizations can and do exist, however, because of the persistence of this type of object gratification which normally is at it height between the ages of ten and fifteen. That it does normally persist in the adult individual is attested to by the success of such organizations as lodges, men's clubs, women's clubs, fraternities, and religious organizations.

THE HETEROSEXUAL STAGE

In the further course of evolution, the average individual shifts his object choice from one of the same sex, a homosexual object choice, to one of the opposite sex, a heterosexual choice. In this stage the sensuality of infancy and the tenderness of latency combine. There is often a tendency to a renewed wave of narcissism, as was indicated above, primarily to attract one of the opposite sex. The individual becomes dissatisfied and ungratified by his attachment to one of the same sex which leads him to the adult stage where his interest becomes directed to one of the opposite sex. In making this shift every individual faces major problems, the chief of which are the emancipation from the home and a reorientation to social sexual life.

The formation of this new object attachment, necessitates the breaking-off of the excessive investment of interest limited to the parents. Not only must the individual give up his dependence on and devotion to the parents as his first love and responsibility, but he must also break his dependence on parental authority. He must of necessity reorient himself in his social life, a problem often of major proportions for the individual. In fact, in some instances, the attachment to the parents or the dependence on their authority is so great that this shift cannot be made and as a consequence this stage cannot be reached. The individual is unable to accept the adult role of masculinity or femininity with the responsibilities and obligations associated with it.

PATHOLOGICAL MANIFESTATIONS

As may now be clear, limited amounts of gratification are derived by the heterosexually mature adult from each of the three earlier sources—auto-eroticism, narcissism, and homosexuality. It is to be presumed that those forms of gratification which can be modified to socially acceptable standards and from which most satisfaction was obtained during these stages are maintained. These are all secondary as sources of gratification if the individual is to grow up to where his final and primary object of gratification must be a person of the opposite sex. Normal expressions of these early stages are exemplified in massage and smoking which are typical carry overs from the auto-erotic stage. Mild exhibitionism and pride are carry overs from the narcissistic stage. Lodge association and comradeships are approved froms of homosexuality.

On the other hand, so much gratification may be obtained from any one of these stages and the obstacles toward progress to a new object may be so great, that the individual may become an adult in years and yet maintain far too great a gratification in an auto-erotic object choice, a narcissistic object choice, or a homosexual object choice. Even more commonly certain undersirable features of one source of gratification are selected and maintained from one or more of the earlier stages, such as gum chewing, nail biting, or gossiping, or an undue interest in bowel movements or enemas. Any of these may be the result of a refusal to give up the object choices made during the auto-erotic period. Severe exhibitionism and masturbation may result from a refusal to forego these forms of narcissistic indulgence which though normal at a certain age are evidences of infantilism in the adult. Likewise, frank homosexual experiences and relationships may be maintained rather than accepting the final mature object choice of heterosexuality.

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ACTIVE SERUM COMPLEMENT FIXATION

DESCRIPTION AND RESULTS OF A SIMPLE METHOD

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At the 1938 Meeting of Serologists, held in Hot Springs, Arkansas, I emphasized the importance of routine active serum complement fixation and proposed to the assembly the inclusion of an active method in the serodiagnosis of syphilis. The following test has been extensively tried by me for more than twelve years, in conjunction with an inactivated serum technique.

TEST

Active serum is diluted 1:2 of 1:3 with saline and distributed in tubes in increasing amounts. By diluting the serum 1:2, only one cc. is needed for the reaction.

The tubes are set in two rows, the first belonging to the reaction proper, the second to the control. In case of insufficient amount of serum, three tubes can be used, this reducing the amount needed to only six tenths of a cc.

TABLE I

SET-UP OF THE REACTION

	Reaction Tubes				*Control Tubes*				*Reaction Control*			
Unknown serum 1:2....	1	2	3	4	1	2	3	4				
Syphilitis serum									1			
Negative serum										1		
Antigen, titrated	1	1	1	1					1	1	2	
Saline	3	1	1		4	3	2	1	3	3	3	5
One Hour in Waterbath at Thirty-seven Degrees												
Sheep Cells 2%, 5%....	2	2	2	2	2	2	2	2	2	2	2	2

(For those who employ a two per cent dilution of sheep cells 0.25 cc. of sheep cells are substituted for the amount above mentioned).

Reading After Twenty Minutes

The control tubes should show complete hemolysis at the end of this time. Should the first tube show no hemolysis, the corresponding tube of the reaction should not be read and results should be based only on the reading of the other three tubes of the reaction. If the second control should show no hemolysis, then the results should be read on the reaction tubes corresponding to completely hemolyzed control tubes.

In the case all the four control tubes show no trace of hemolysis add one or two units of hemolysis to all the tubes. By experience I have noted that hemolysin is more often absent than complement. Sometimes the heterophile hemolysin present in the hu-

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man blood is scarce and may fail to show activity even in the fourth tube, containing two-tenths of a cc., but, in presence of a small amount of isophile hemolysin, it shows strong synergistic action. After twenty minutes take a reading. If the control tubes show hemolysis, then read the results and record.

If the control tubes show as yet no hemolysis, then complement is not present in the serum, or is very scarce. One has in this case the choice to either repeat the reaction and add one unit of complement to the reaction tubes before the first incubation, or to add complement directly to the tubes. I have followed this last procedure with constantly good results. Syphilitic sera will give positive reaction even with such an apparently unorthodox procedure. From a long series of experiments which I have carried out it seems clear that the fixation of complement by antigen-antibodies complexes takes place more promptly than by hemolysin-sheep cells. Therefore, in case of positive serum, the complement will be fixed by the antigen-antibodies with the result that no hemolysis take place, even if the addition of complement takes place after the addition of hemolysin-sheep cells. The presence of cholesterol in the antigen will facilitate the promptness of fixation of complement upon antigen-antibody complex, by its retarding action upon hemolysis.

COMPARISON WITH INACTIVE SERUM METHODS

For comparison two inactivated serum methods have been chosen, one a modified Calmette and Massol technique, and the other Kolmer. The Calmette method was run in this same laboratory, and therefore using the same antigens as in the active method; the Kolmer was run in the State Public Health Laboratories. The same blood specimens were divided in two portions, one retained in this laboratory and the other forwarded to the State Laboratories.

The comparison was carried out on 100 paretics, inmates of this institution, who, by clinical and previous serological tests, had been diagnosed as such.

Table II shows the results obtained by comparing the active serum method with Calmette technique:

TABLE II

100 Paretics (Treated and Untreated)

Active serum positive	74
Per cent positive	74%
Inactive serum positive	62
Per cent positive	62%

83 Untreated Paretics Active Serum

Positive	74
Per cent positive	89%
Inactive serum positive	62
Per cent positive	74%

Positive with active serum, but negative with inactive	18
Positive with inactive, but negative with active serum	6
Active serum more strongly positive	*14
Inactive serum more strongly positive	*11
Active serum doubtful, but inactive serum negative	2
Inactive serum doubtful, but active serum negative	2

TABLE III

88 Cases, Including All Cases of Syphilis, Treated and Untreated

Active method positive	58
Kolmer positive	52
Kolmer anticomplementary	5
Active method per cent positive	66
Kolmer per cent positive	59

75 Cases Syphilis Central Nervous System, Treated and Untreated

Active method positive	52
Active method negative	23
Kolmer positive	44
Kolmer negative	26
Anticomplementary	5
Active method per cent positive	69.3
Kolmer per cent positive	58.4

Active serum more strong	15
Kolmer more strong	5
Active method positive, but Kolmer negative	5
Active method positive, but Kolmer anticomplementary	4
Active method negative, but Kolmer anticomplementary	1
Kolmer positive, but active serum negative	None

I have not attempted to compare the two inactive methods between themselves as it is outside the scopes of my investigation. It seems to me, however, that the reason of better performance of the Calmette lies not in the set-up of the test itself, but in the choice of the antigens, as it will be shown in the next paragraph.

COMPARISON OF ANTIGENS

No antigen can be considered best under any circumstances. Therefore, the need for multiple antigens is, in my opinion, imperative. It happens very often that the same serum will show different results with different antigens and the same antigen will vary in degrees of fixation with different serums.

I have tried several antigens in connection with my own active method and the Calmette-Massol method. -The results obtained can be seen from the table below:

TABLE IV

Antigens	*Number of Cases*	*Number Showing Stronger Fixation*
Noguchi Acetone, insoluble	40	15
Cholesterolized Lederle	39	9
Kolmer, new	38	1*
Kolmer, old	39	7*
Boerner	38	16
Boerner Jones Lukens	29	14

*Equal to some other antigen, but never stronger than any other antigen used in the test.

In this column is reported the number of times the antigen has shown definite stronger fixation in respect to the other antigens used for the same test.

Not all antigens give the same results with active and inactive serum. Noguchi's antigen gives best results with active serum, but in this small series in which tests were run with all the six antigens, Boerner and BJL have shown to be equally good and sensitive. The cholesterolized antigen of Lederle has the fault of being rather erratic and anticomplimentary, a fault which it shares with many other commercial antigens. It could not be strongly over-emphasized to secure a supply of antigen conforming to the rigid standards set by the author of the antigen.

The two Kolmer antigens have not shown their superiority in sensitivity, but, of course, this statement applies only to the work carried out in this laboratory. The old Kolmer antigen is certainly better than the new cholesterolized and lecithinized antigen. It seems to me that the new antigen contains substances which may tend to neutralize each other. In some experiments I have carried out on the influence of lecithin and cholesterol on hemolysis, I have found that lecithin is an accelerator and cholesterol a retarder of hemolysis. Lecithin may mask the anticomplimentary activity of the antigen, whereas cholesterol would tend to increase it. Whether the addition of the lecithin fraction would improve the quality of the antigen is still a very debatable point. It is known from a series of experiments by Ascoli that lecithin and cholesterol have opposite influence on the surface tension of the serum.

ADVANTAGE OF THE NEW METHOD

It seems to me that there are three types of reagins involved in the serological diagnosis of syphilis. They are: (1) Thermostable reagins. They will react in both active and inactive serum with the same intensity. (2) Thermo-labile reagins. They will disappear on heating the serum at fifty-six degrees and therefore will not show in the inactive serum methods. (3) Thermophilic or phenothermic reagins. They appear in the serum only after inactivation at fifty-six degrees. Many flocculation reactions are based exactly upon the appearance of these reagins, for both active and inactive methods. Serums containing thermostable reagins will respond to either active or inactive methods with the same intensity; serums containing thermo-labile reagins may show a strongly positive fixation with active methods and be entirely negative with inactivated method; serums containing thermophenic reagins will give positive results with the inactive method and negative with active method. This last occurrence is rare, but in the field of serology one should not overlook any method to secure maximum of sensitivity within the limits of specificity. During treatment and in many cases of latent syphilis, especially of the central nervous system, the thermo-labile reagins are very often the only ones to persist the longer. In such event only the active complement fixation may aid to detect syphilis in these individuals who need the prompt attention of the doctor. In view of early malaria inoculation we would gain more assurance on the course of treatment if we would check our results with an active method rather than to rely upon an inactivated serum test in which the only remaining thermo-labile reagins had been destroyed.

I have carried out a number of blood cholesterol determinations on these same patients in conjunction with the Bordet Wassermann, but have been unable to find any correlation between cholesterol level in the blood and positivity in the serum. For sake of brevity I will not present the table showing these negative results. Cholesterol in positive serum oscillated widely between 130 and 250, and such oscillation was just as wide as in negative cases.

ADVANTAGES OF THE TECHNIQUE

1. It has been noted in all the techniques on active serum and by its original author, Hugo Hecht, that some serums having high hemolysin content may eventually give false negative results. In my technique to avoid this inconvenient, more theoretical than real, I make use of gradually increasing amounts of serum and compare every reaction tube with its respective control tube. The first tube, which contains the least amount of serum, contains also a smaller amount of hemolysin, and therefore in serums with high hemolytic index, its positivity will not be influenced by this factor. It is noteworthy that in the tables presented, there is not a single case of Kolmer reaction being positive with a negative active serum. This fact alone pretty well disposes of this idea of false negative.

The use of gradually increasing amounts of serum eliminates the danger of too active hemolysis, though one could, if the hemolysis takes place in the first ten minutes, add more cells to all the tubes and watch the course of hemolysis. In an investigation I carried out some years ago on relation between hemolytic index of serum and positivity I have noted that syphilitic serums lose gradually their content in natural hemolysins, thus lessening the danger of too active hemolysis.

2. Increasing amounts of natural complement are used in the tubes. The test is more likely quantitative than the one tube techniques used in many routine tests.

3. Increasing amount of reagins, which are mixed with the same amount of antigen, contribute to a

more sensitive measurement of the complement fixation.

4. The dilution to one-half of the serum and the avoidance of heating decreases the chances of aspecificity. In cases of malaria, for example, the dilution of serum will prevent a specific fixation, as I have noted many times in the course of tests. In leprosy, heating favors the formations of pseudo-reagins, therefore causing false positive results. The use of active serum eliminates such important source of error. I have tested a large number of serums from malaria and leprosy patients, while in Central America and have noted that these serums show negative results with the active method, whereas they showed a large percentage of positive results with inactive serum methods.

5. Scarcity of anti complementary reactions. From our tables we note that the Kolmer test shows a rather high percentage of anti complementary reactions (Kolmer was not run in this laboratory but in the State Public Health Laboratory). One of the reasons, but by no means the only one, is in my opinion the fact that the test employs only two units of hemolysin. Though not admitted, the simplified test relies upon the presence of natural hemolysin in the serum—and, when this hetherophile hemolysin is absent or scarce—as it is in the case in syphilitic serums—or removed, as suggested in some cases of Kolmer, the test may give anticomplementary result. In a series of titrations carried out by Gold and Gerundo designed to establish reciprocal relations between complement and hemolysin, the results do not change by using two, four or six units of hemolysin. According to this work, eight or ten units of hemolysin are necessary to reduce the amount of complement to one-fourth of a unit. It may well be that the use of a larger amount of hemolysin may lessen the number of anticomplementary reactions in the Kolmer test. Calmette advised the use of ten units of hemolysin in his test, and the results of Calmette's test are, at least, not inferior to any of the better Wassermann methods. Even if such amount of hemolysin as suggested by Calmette were not used, four or six units can be used without changing at all the results.

In paresis, during a malaria treatment the blood often becomes anti-complementary. From a follow-up of a number of treated patients I gather the impression that this short period of complete anti-complementary activity is followed by a period during which the serum lacks complement, but it is not anti-complementary, and finally by return to the normal.

SUMMARY AND CONCLUSIONS

A simple method for active serum complement fixation is described, and its results compared with standard tests. The need of employing an active method in conjunction with one inactivated serum method is emphasized. In the performance of the tests, the use of multiple antigens is suggested, to obviate the rather erratic differences of fixation shown by many antigens under various circumstances. The advantages of the active method are discussed, particularly in relation to the various types of reagins present in syphilitic serums.

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According to the annual yearbook of the National Safety Council, entitled "Accident Facts," 102,500 persons were killed in accidents in 1941. Motor vehicles accounted for 40,000 deaths and accidents in the home for 31,500. Motor accidents were responsible for injuring 1,450,000 persons and accidents in the home for 4,650,000. Other public accidents of all kinds were responsible for the deaths of an additional 15,000 persons and the injuries of 1,800,000. The National Safety Council points out that ninety-seven per cent of the total accidents were preventable and cost the nation $4,000,000,000. On the job accidents killed 18,000 workers, injured 1,600,000, cost $850,000,000 and resulted in the loss of 460,000,000 man-days of work during 1941. Every type of motor vehicle accident except collisions with street cars showed a higher fatality total in 1941 than 1940. The bulk of the total increase came in collisions between motor vehicles, which were up twenty-four per cent; collisions with bicycles, up twenty per cent; collisions with fixed objects, up twenty-three per cent, and non-collision accidents, up twenty-one per cent. Deaths from motor vehicle-train collisions at grade crossings numbered 1,834 in 1941. This was even fewer than occurred in 1923, when motor vehicle travel was only a fraction of its present volume and when far fewer trains were operating than in the preparation for defense period of 1941. The release pointed out that of thirty-one industries studied the aeronautics industry was among the top five for 1941 in terms of both accident frequency and severity. Workers in the aeronautics industry suffered only 7.40 disabling injuries per million man-hours as compared with an average of 15.39 for all thirty-one industries. Of the 40,000 persons who were killed in automobile accidents 8,000, or one in five, had been drinking. State summaries for 1941 showed that eleven per cent of the drivers involved in fatal accidents had been drinking and that fourteen per cent of the pedestrians killed had been drinking, 1,900 of the 13,600 pedestrian deaths. Summaries for the twenty-two states showed twenty-seven per cent more drinking drivers than were involved in fatal accidents for 1940.—Journal of the Missouri State Medical Association.

President's Page

To the Members of The Kansas Medical Society:

In assuming the presidency of The Kansas Medical Society, the highest professional honor that can be bestowed upon me, I fully realize that the years of 1943-1944 will present many problems and that these problems can only be solved if you, the members of our Society, are willing to give of your time and thought to the solution. In making committee appointments, I realize that travel and time must be conserved, yet The Kansas Medical Society must carry on, thus it will be necessary that committee men respond to the call of their chairman. It will be necessary to have meetings of several of these committees within a very short time.

Your officers will do their best to carry out your instructions as it pertains to re-writing of the medical practice act, handling of the cultist situation and many other important matters.

I would greatly appreciate letters from any members of the Society pertaining to any medical problem in your community.

Sincerely,

J. L. Lattimore M.D.

President, The Kansas Medical Society

EDITORIAL

ANNUAL MEETING

The 84th Annual Meeting of The Kansas Medical Society is now a matter of historical record. Having, by Council decision, canceled the usual scientific technical and social activities of the meeting and streamlined the usual time of three days to one day, on May 8-9, approximately one hundred members, mostly officers, councilors and committee chairmen, met at the Hotel Jayhawk in Topeka to confer, advise and guide the progress of Kansas medicine for the coming year and to elect the next year's officers.

Some few of the membership arrived in the afternoon but many, due to increased professional activities and transportation arrived just in time for the dinner meeting. The dinner was followed by a House of Delegates Session. The Reference Committee under the chairmanship of Dr. Charles Rombold of Wichita, Dr. A. W. Fegtly and Dr. John Grove, had reduced the usual voluminous reports, most of which were published in the April issue of the Journal, to a few lines or paragraphs. This method of procedure which has been used the past few years has greatly reduced the actual time consumed in the House of Delegates. Reports not previously printed were given in detail. The reports of Dr. Geo. M. Gray, the Treasurer; of Mr. Robert Brooks, the Executive Secretary; of Dr. W. M. Mills, the Editor of the Journal; and of Dr. F. L. Loveland, Kansas Chairman for Procurement and Assignment, who reported on the war participation and activities of that committee, were given in person. Dr. Loveland advised the membership of the importance of returning the reclassification cards for the War Manpower Commission. If you have not sent in your reclassification card it is imperative that you do so at once. The information on these cards is being requested from the national office and must be secured in the shortest time possible.

Dr. Henry N. Tihen, retiring President, gave his address, which may be read in full in another part of this issue of the Journal. He reviewed the activities of the Society and the profession for the past year. Dr. John L. Lattimore of Topeka, incoming President, gave a short talk which was followed by the regular business meeting.

The second session of the House of Delegates convened at 9:00 a. m., on Sunday, May 9, followed by the Council meeting at 11:00.

High lights of the meeting in brief are as follows: Need for informing the public and legislative bodies, both state and national of matters of importance to public health and medicine was emphasized. Several decisions were made in this regard. There is no "doctor shortage" in Kansas, although hue and cry has been raised by many publications in other states. In this regard the membership pledges its cooperation, either individually or collectively, to furnish adequate medical care for all communities in the state. This may be done by county society organizations acting jointly or by schedule days in towns where there are no residence physicians.

Although very brief the meeting was a most successful one.

PRESIDENT-ELECT

The Society is most happy to announce Marion Trueheart, M.D., of Sterling, as its new President-Elect for 1943-1944.

Dr. Trueheart has been most active in Society matters for many years, serving as its Second Vice-President in 1941-1942 and its First Vice-President in 1942-1943. He was Councilor for the Fifth District from 1935-1941, the maximum period of two terms, and has served on many Society committees both as a member and as chairman.

During the first World War, Dr. Trueheart served as a Captain in the medical corps and on July 31, 1918, was sent oversea where he had considerable active medical experience. He is a fellow of the American Medical Association; a member of the American Board of Radiology, the American College of Surgeons, the American Urological Association, the Radiological Society of North America, Inc., the American College of Radiology and the American Radium Society.

The Society has acted wisely in selecting a man with previous war experience who will make an able leader in the field of Kansas medicine.

VIRUS PNEUMONIAS

"The problem of pneumonias due to bacterial agents, although not completely solved, has nevertheless been gratifyingly modified in the majority of pneumonia patients. The causative organism can usually be demonstrated in the sputum or from nasopharyngeal cultures; the clinical and x-ray pictures have been well defined, and a definite regimen of treatment by chemotherapy and other measures has been standardized. The improvement in the prognosis of bacterial pneumonias has been one of the most satisfying features of modern medicine.

"A familiar pneumonic syndrome, strikingly dif-

ferent from the above, has been reported in the literature with increasing frequency.[1,2,3,4,5] The following are some details in which this "atypical" pneumonia differs from the ordinary or classic pneumonia:

"The incubation period may be longer, sometimes as long as two weeks. The cough is unproductive and apt to assume a hacking nature. The temperature curve is more irregular, rises slowly, and falls by lysis in from a few days to two to three weeks. Headache, photophobia, and sweating are frequent concomitant symptoms. The leukocyte count is essentially normal. No bacteria found in the sputum or rhinopharynx can be associated with the disease. The pneumonic signs and x-ray picture are those of scattered infiltrations, often of a migratory nature. Sulfonamide therapy is futile; complications are unusual; and the mortality is low. In the few autopsies reported, the histologic reaction of the involved lung has been composed chiefly of mononuclear cells, and no bacteria have been found.[4] Cytoplasmic inclusion bodies have been observed in the lungs of infants dying of this form of pneumonia.[5] Because of the atypical clinical and x-ray findings, the pathologic reports of a mononuclear reaction in the areas of pneumonitis, and the resemblance of this response to the pneumonias caused by known virus agents, the term "virus pneumonia" has been suggested for this peculiar but definite pneumonic syndrome.[3,5]

"Attempts to find the direct causative agent in such pneumonias have led to the isolation of a virus which differs from the previously known influenza virus.[6] Further research into the virus that causes this form of pneumonitis, by means of immunologic studies and neutralizing tests, has brought to light a remarkable cross relationship between this pneumonic virus, or viruses, and those of psittacosis, meningopneumonitis, and lymphogranuloma venereum.[7] This opens a fascinating field in the study of pneumonias and their relationship to contagion to and from animals, including household pets.

"Suffice it to say that it is of the utmost importance to be able to recognize or suspect this pneumonic syndrome and its epidemiologic implications. A simple, confirmatory test may be the demonstration of inclusion bodies in the large mononuclear cells in the stained sputum of patients who have this disease.[5] One of the sulfa drugs may be employed, with the thought of preventing secondary invasions, which are not uncommon in influenza pneumonia.[8] If a short period of observation reveals no effect from the drug, it is wise to discontinue its use; otherwise toxic effects may ensue, to the detriment of the patient's condition."—From the New York State Journal of Medicine

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TUBERCULOSIS CONTROL

WAR CHALLENGES THE GENERAL PRACTITIONER

Under the stress of war it has been observed that conditions favor the spread of pulmonary tuberculosis. Probably an increase in the disease has not occurred to date in this country as a whole, but a rise has occurred among other belligerent nations and in some of our own industrial centers.

Increase in prevalence and mortality can be traced to inadequate diet, insufficient institutional facilities and medical care, lowering of resistance from apprehension and disturbed rest, and overcrowding and poor housing in areas of concentrated war industry.

Since the disease appears on the increase in countries at war longer than ours, it must be assumed a similar trend is to be anticipated here. This calls for early diagonsis, hospitalization of active cases and discovery of infective contacts. Greatest hope for success lies in the interest and co-operation of the early practitioner. He sees the patient early and through his intelligent effort will come early diagnosis, prompt isolation and the investigation of contacts. Toward this goal we shall indicate a path for the practitioner, who, deprived of many a colleague, finds his problems multiplied and his strength and time in no wise reinforced.

Usually it is easy for a tuberculosis specialist to make a diagnosis once the suspect has been singled out by the practioner. More difficult is it for the latter to give due consideration to tuberculosis—only one of many conditions that may assail his patient.

For example, cough is the most common symptom of the disease. In one with a history of previous acute pleurisy, chronic cough is very suspicious. Nevertheless, the disease may be present without it, and most agree that cough or any other symptom is a relatively later, not an encouragingly earlier manifestation of pulmonary tuberculosis. If we persist in describing tuberculosis in terms of symptoms, we might as well omit further discussion of

early diagnosis, even though we admit that knowledge of classical symptoms is essential if we are to have tuberculosis in mind when we encounter those less fortunate cases long past the stage when early discovery was possible. These symptoms include fatigue, particularly in the late afternoon, loss of weight, low-grade fever, chest pain and hemoptysis.

If tuberculosis is to be found preclinically or at onset of its earliest symptoms a thorough, practical and economical plan of attack is necessary. Weapons on hand include history, physical examination, tuberculin test, sputum examination, x-ray and fluorscopy.

Tuberculosis specialists generally feel that the greatest deterrent to early diagnosis by the practitioner is the expense of x-ray examination. If it were as easy to x-ray the lungs as to do a physical examination many more early cases would be found. Where x-ray facilities are handy it is simpler to take a picture and study it than to do a physical examination, which, though thorough, may fail to disclose the trouble. Most practitioners lack office x-ray facilities, but the truth remains there is no substitute for a good x-ray picture. Today, in all but the most rural communities, arrangements can be made for x-ray of the chest in the indigent as well as in others.

Physical examination may uncover rales, breath sound changes, etc., but their absence does not mean absence of tuberculosis. In every sanatorium are patients with far advanced disease who have been told by their family doctors that no signs of tuberulosis were present. Similar oversight may occur in some early cases when symptoms are present as well as positive x-ray findings. This is no reflection upon the skill the physician but proves that symptoms and x-ray evidence are often present before definite physical signs of tuberculosis develop.

Fluoroscopy, even in the hands of experts, is not as accurate as film methods in diagnosing tuberculosis. Serial pictures, too, give better clues as to the progress of leisons than mere observation of the clinical record.

The tuberculin test, variously conducted, is of value in the process of screening groups or studying individuals. A positive test shows that the skin has been sensitized by previous or present tuberculous infection. It does not prove that active pulmonary disease is present, but does call for an immediate chest x-ray. A negative test, conversely, is almost conclusive that active tuberculosis does not exist. There are exceptions to this statement, but they are rare.

Sputum examination is vital. A positive sputum leaves no doubt that active disease is present, but a negative sputum is no guarantee of its absence. There may be relatively few bacilli in a sputum sample; improper collection may provide saliva instead of thick material truly expelled from the lung by a spell of coughing; or too few samples may be examined. Reinforcing the simple smear are concentration methods, culture or guinea pig inoculations, and examination of the fasting gastric sediment in those swallowing their sputum.

Tuberculosis cases should be reported promptly to the public health authorities who assist in determining their disposition.

Many practitioners are not interested in treating tuberculosis patients. Others feels they see cases so rarely that they would welcome assistance by experts. Sanatorium care, if available, promises conditions ideal for treatment and training of the patient and protection of his family and friends.

People who contract pulmonary tuberculosis usually do so because of intimate exposure to someone with a positive sputum. Thorough search is made in the patient's household and among his other associates, each being tuberculin tested and the positive reactors x-rayed. Obviously the x-ray, if showing nothing at first, should be repeated at four-month intervals for several years, as breakdown may be slow to appear.

Many counties have well organized tuberculosis associations whose nurses serve as field workers. Granted this aid, the social side of the problem can be handled with personal home interviews, transportation of the patient to the sanatorium or clinic and of the contacts for testing and x-ray. Tuberculosis workers are well trained and function to give the practitioner able service and advice about the disposition of the case, the adjustment of the family and in follow-up of the patient once he leaves the sanatorium.

The family doctor should co-operate with those who have directed the treatment when he receives back the discharged case. Rehabilitation in these people is complex and important. Many sanatoria have personnel specially trained to instruct patients in occupations they will be fitted to carry on after their cure, or to prepare them for the special problems facing them upon their return to society. The family doctor must continue his interest through both treatment and rehabilitation periods, with periodic check-up, assurance and advice.

The greatest contribution the general practitioner can make in the field of tuberculosis in wartime is the intensification of his peacetime effort, keeping the disease constantly in mind and remembering that the ultimate ideal in controlling tuberculosis would be to have every adult x-rayed annually.—From Tuberculosis Abstracts, April 1943. General Practitioner's Role, Paul Geary, M.D., Bulletin of the National Tuberculosis Association, March, 1943.

NEWS NOTES

INDUSTRIAL HEALTH INSTITUTE

Two wartime industrial health institutes will be held, the first in Kansas City on Thursday, June 3, and the second in Wichita on Friday, June 4. The program will be presented in an afternoon and an evening dinner session.

Complete plans for the meetings have been under the sponsorship of the Sociey Committee on Industrial Health, of which Dr. Charles Rombold is chairman and the Kansas State Board of Health.

An incomplete list of the speakers who will appear on the program is as follows: A. G. Hewitt, General Manager of the Visking Corporation of Chicago; Dr. Paul B. Magnuson of Chicago; Voyta Wrabetz, Chairman of the Wisconsin State Industrial Commission of Madison, Wisconsin; Dr. Floyd Beelman of Topeka, Secretary of the Kansas State Board of Health; Dr. Ray Hill of Fremont, Nebraska, Medical Director of the Nebraska Defense Corporation; Dr. F. L. Loveland of Topeka; Dr. Carl M. Peterson, Secretary of the Council on Industrial Health of the American Medical Association of Chicago.

Special invitations will be extened to labor representatives, industrialists, and to all physicians interested in a health program for industry.

DEFENSE BOARD MEMBER APPOINTED

Dr. Henry N. Tihen of Wichita, retiring President of the Society, was announced by the Council as a new member of the Society Defense Board. Dr. L. S. Nelson of Salina, is at present the Defense Board Chairman.

NEW EDITORIAL BOARD MEMBERS

At a meeting of the Council, held in Topeka on May 9, Dr. Robert Knight and Dr. Ernest Decker, both of Topeka, were announced as members of the Editorial Board for the Journal. Dr. Knight succeeds Dr. R. B. Stewart, formerly of Topeka and now of Los Angeles, California, whose term as Board member had not as yet expired, and Dr. Decker succeeds Dr. L. E. Eckles, who is now serving in the armed forces.

POST-GRADUATE COURSE

The Scientific Works Committee of The Kansas Medical Society in conjunction with the University of Kansas School of Medicine and the Kansas State Board of Health is sponsoring a post graduate clinic on tropical diseases. The first clinic will be held in Emporia on May 22-23 commencing at 6:15 p.m.

It is the idea of the Committee on Scientific Work which is making plans for the series of clinics, that succeeding clinics will be held in Wichita, Salina, Parsons, and Kansas City or Topeka. The post graduate course will have facilities for fifty physicians in each clinic and it has been found that many physicians in the districts where the clinics will be held are most eager for an opportunity to do post graduate work in the field of tropical medicine, which will undoubtedly be a required course in the medical school curriculum of the future.

The faculty of the clinic will be as follows: Dr. H. L. Douglas of the University of Kansas School of Medicine; Dr. H. B. Hungerford, Professor of Entomology of the University of Kansas, Lawrence; and Miss Mary E. Larson, Department of Zoology of the University of Kansas at Lawrence. The following subjects will be discussed: "Malaria and Its Control" with laboratory diagnosis, epidemiology, clinical and therapeutic aspects of the disease being discussed; "The Dysentaries and Their Control" and "Other Tropical Diseases." The registration fee of $3.50 will be charged and $1.00 for the dinner meetings to be held on Saturday night, May 22. For further information write to the central office or to Dr. Philip Morgan, of Emporia.

MEETING

A special meeting of Society officers, councilors, and members of the Committee on Public Policy, the Committee on Medical School, the Committee on Scientific Work and the Kansas State Board of Medical Registration and Examination, was held at the University of Kansas School of Medicine in Kansas City on Sunday, May 11, 1943.

The meeting of the Board of Medical Registration and Examination preceded the other meetings. Mr. Clarence Beck, attorney for the board discussed the medical practice act.

Post graduate plans for the year were discussed, as was the legislative policy of the Society for the coming year. Dean H. R. Wahl, of the University of Kansas School of Medicine, gave a brief resume of the activities of the medical school; Chancellor Dean Malott, of the University of Kansas at Lawrence, spoke and Dr. Henry N. Tihen discussed the post graduate possibilities for the year. Dr. F. J. McEwen of Wichita, reviewed the possibilities of refresher courses for physicians returning from the armed forces to civilian life and Dr. L. B. Spake of Kansas City, newly appointed member of the Board of Regents, gave a short talk.

Following the business meeting, Dean Wahl and Chancellor Malott were the hosts to the group at a dinner in the new wing of the hospital. The meeting was unusually well attended.

APPOINTMENT TO BOARD OF REGENTS

Governor Schoeppel on April 2, 1943, announced the appointment of Dr. L. B. Spake of Kansas City, as a member of the Board of Regents. The appointment term is for three years and will expire on December 31, 1945.

BOARD OF HEALTH APPOINTMENTS

Governor Andrew P. Schoeppel announced on April 2, the reappointment of the following as members of the Kansas State Board of Health: Dr. Forrest L. Loveland of Topeka, Dr. H. L. Aldrich of Caney, Dr. G. A. Leslie of McDonald, Dr. George I. Thacher of Waterville and Dr. Hugh A. Hope of Hunter. The term of office of Dr. Loveland and Dr. Hope expires in March, 1944, and the term of office of Dr. Aldrich, Dr. Leslie and Dr. Thacher expire in 1945.

On April 21, Governor Schoeppel announced the appointment of Dr. Clyde D. Blake of Hays, President of the Society in 1941-1942, as a member of the Board of Health. Dr. Blake's term of office will expire in 1945.

JOURNAL DESK

Changes in mailing addresses both for men in the service and for our own men at home arrive in every mail delivery. We are attempting to make these changes as rapidly as possible in order that you will not miss a single issue of the Journal. Please send your former address when asking for a change, and if possible give the date of the new change in order that Journals being mailed with in a day or two of the change will be stopped and sent to your new address. Interesting bits of information are included with many of the notes received, some of which cannot be printed due to censorship regulation. However, it is interesting to keep in touch with the travels of our members.

Capt. H. P. Jones, formerly of Lawrence, is now with the 15th Evacuation Hospital Motorized, APO, New York.

Lt. Lewis L. Robbins, formerly of Topeka, is now stationed at Drew Field, Tampa, Florida.

Capt. L. L. Cooper, formerly of Fort Scott, is now stationed in San Antonio, Texas.

Capt. C. G. Davis, formerly of Kansas City, is at present in Abilene, Texas.

Lt. R. E. Bula, formerly of Lyon, is now in Mairmont, Minnesota.

Lt. Clovis W. Bowen, formerly of Valley Falls, is now in Salina.

Lt. D. A. Anderson, formerly of Salina, is now in San Diego, California.

Capt. R. S. McKee, formerly of Leavenworth, has been transferred from Nevada, Missouri, to Brownwood, Texas.

Lt. Comdr. D. A. Ward, formerly of Arkansas City, has been moved from Corpus Christi, Texas, to Norman, Oklahoma.

Major Don C. Wakeman, formerly of Topeka and a member of the Editorial Staff of the Journal, has recently been transferred from Fort Riley, to the Mayo Clinic, Rochester, Minnesota, for post graduate training.

Major Richard E. Speirs, formerly of Spearville, has been transferred from Salina to Fort Leonard Wood, Missouri.

Capt. K. J. Gleason, who has been stationed at San Louis Obispo, California, was in the central office for a few minutes visit. Capt. Gleason is being transferred to Camp Rucker, Alabama.

Major Maurice Snyder, formerly of Salina, is with the 77th Evacuation Unit with a New York APO address.

Major William Scales, formerly of Hutchinson, from Riverside, California, to Terminal Island, California.

Capt. W. G. Weston, formerly of Arkansas City, to Caramel, California.

Major Garth S. Ortman, Flight Surgeon, formerly of Kansas City to Albuquerque, New Mexico.

Major Dale C. McCarty, formerly of Nashville, from Rockford, Illinois, to General Hospital, Harahan, Louisiana.

Lt. Comdr. L. E. Eckles, formerly of Topeka, from the National Navel Medical Center at Bethesda, Maryland, to the Great Lakes Training Station.

Dr. Alexander J. Berger has moved from Arkansas City to Parsons.

Dr. Jacob R. Heryford has recently moved from Fairview to Hiawatha.

Dr. J. W. Spearing who has been in Parsons for some time has recently returned to Columbus.

Lt. L. A. Donnell, from Palo Alto, California, writes, "I enjoy getting the Journal, please continue it to my new address: Fleet P. O., San Francisco, California."

A letter from Dr. Joseph W. Manley, formerly a Lieutenant and from Kansas City, now a Captain, says "Several of us read the Journal and really look forward to each issue. We appreciate the service and hope you can keep it coming. My old address was Los Angeles, California, address the Journal now to Camp Rucker, Alabama."

MEMBERS

The Kansas Peace Officer, a bi-monthly publication of the peace officers association, listed Dr. L. A. Moore of Herington, Dr. A. E. Hertzler of Halstead and Dr. H. E. Haskins of Kingman, as the "three musketeers" of the Peace Officers Convention, which was held in Wichita in May. The doctors were each awarded war bonds as prizes at the annual state pistol shoot held during the convention.

Dr. Francis C. Basham, Dr. James J. Basham and Dr. John H. Basham of Eureka, have recently purchased the Hotel Lindon in Eureka, which is to be converted into a hospital, if the approval of the War Production Board can be secured.

Dr. W. M. Mills of Topeka, presided at the War Session of the American College of Surgeons held in Kansas City, Missouri, on April 1, 1943.

Dr. T. W. Reid of Gardner, recently announced plans for the reopening of the Reece Hospital in Gardner. The hospital has been closed due to a shortage of hospital personnel.

Dr. L. S. Nelson of Salina, was elected President and Dr. E. M. Sutton of Salina, Secretary of the Golden Belt Medical Society, at a recent meeting of that organization.

Dr. Leo Crumpacker of Wichita, has recently been made a member of the American Board of Surgery.

Dr. W. T. Elnen of Wichita, is in Chicago where he is doing post graduate work at the Cook County Hospital.

Dr. E. M. Seydell of Wichita, has recently been elected as a member of the Board of Trustees of the American Medical Association and as a member of the editorial board of the publication Archives of Otolaryngology.

Dr. Arthur E. Hertzler of Halstead, was the speaker at the Jackson County Medical Society meeting held in Kansas City, Missouri, on February 23. Dr. Hertzler discussed "Goiter—a Continuous Process."

Dr. R. M. Sorensen of Topeka, Director of Venereal Disease Control of the Kansas State Board of Health, presided at the afternoon session and the dinner of the seventeenth annual meeting of the Iowa Public Health Association in Des Moines on April 27. Dr. Sorensen is the President of the organization.

The article, "Acute Otitis Media and Mastoiditis," by Dr. Ernest Seydell of Wichita, which was originally published in the Southern Medical Journal for July, 1942, was abstracted in the Oklahoma Medical Journal for March, 1943.

The article, "Intravenous Fluids," by Dr. J. L. Lattimore of Topeka, published in the October, 1942, issue of the Journal was reprinted in brief in the January, 1943, issue of Philadelphia Medicine.

The Second Volume of the new Medical Journal Abstracts published to E. R. Squibb and Sons of New York, contained abstracts of two articles originally published in the Journal: "Appendicitis in St. John's Hospital," by Dr. John C. Mitchell of Salina, in the November, 1942, issue and "Sulfathiazole," by Robert Forney of Topeka, in the December, 1942, issue.

Dr. A. R. Adams of Leavenworth, has recently been appointed health officer of the city of Leavenworth.

The article entitled, "Treatment of Nail Puncture Wounds of the Feet," by Dr. Maurice A. Walker, formerly of Kansas City and now in the armed forces, was abstracted in the March, 1943, issue of the Current Medical Digest.

Dr. Harlan Crank, formerly of Topeka and now in the United States Navy, was a speaker at the 1943 Conference of the Iowa Association for Social Welfare, which was held in Des Moines on April 9-10. Dr. Crank's subject was, "Lessons to be Learned from Military Examination of Our Youth." Dr. Crank is psychiatrist in the Navy Pre-Flight School at Iowa City, Iowa.

COUNTY SOCIETIES

The Butler-Greenwood County Medical Society held a meeting in El Dorado on March 12, at which Dr. W. P. Callahan of Wichita, was the guest speaker. At the April 9 meeting of the Society, Dr. J. E. Woolfe of Wichita, spoke on "Poliomyelitis."

At a meeting of the Cherokee County Medical Society, held on May 5, Dr. William McKinney of Baxter Springs, was elected as Secretary to fill the unexpired term of office due to the death of Dr. W. H. Iliff the former Secretary.

The Clay County Medical Society held a dinner meeting in Clay Center on April 14. Dr. Warren Morton of Green, read a paper on, "The Primary and Secondary Anemias." The May 12 meeting of the Society was also held in Clay Center with Dr. Francis C. Shepard of Clay Center, presenting a paper on, "Hypertension Complications."

The Cowley County Medical Society held a meeting in Winfield on February 18. Dr. Fred Mayes of the Kansas State Board of Health at Topeka, spoke on, "The Kenny Treatment in Infantile Paralysis." At the April 15 meeting of the Society Dr. R. L. Ferguson of Arkansas City, discussed some Eye, Ear, Nose and Throat Case Histories; Dr. Harold Jones of Winfield, discussed "Diseases of the Skin," and Dr. H. L. Hiebert of the Kansas State Board of Health, spoke on "Tuberculosis." Dr. F. A. Kelley of Winfield, Dr. H. M. Stricklin of Arkansas City and Dr. W. F. Bernstorf of Winfield, were chosen as Delegates to the State meeting.

The Central Kansas Medical Society held a scientific meeting in Hays on April 13. Dr. Don Carlos Peete of Kansas City, was the guest speaker at an afternoon session, followed by a dinner meeting.

The members of the Cloud County Medical Society were guests of the staff of the St. Joseph Hospital of Concordia at a dinner held on April 7. A symposium on stomach ulcer with sound films on the subject followed the dinner.

The Leavenworth County Medical Society held a meeting in Leavenworth on May 3. Dr. H. L. Hiebert and Dr. Charles Hunter of the Kansas State Board of Health, discussed "Recent Trends in Tuberculosis Testing."

The Mitchell County Medical Society held a meeting in Beloit on April 6. Dr. S. T. Millard of Topeka, conducted a skin clinic.

The Neosho County Medical Society held a meeting in Chanute on April 2 and elected the following: Dr. R. A. Light as President, Dr. R. H. Rollo as Vice-President, Dr. J. A. Butin as Secretary-Treasurer and Dr. A. M. Gartin as State Delegate. All of the officers are from Chanute.

The Republic County Medical Society and the Labette County Medical Society in conjunction with the Kansas Crippled Children's Commission have recently sponsored crippled children's clinics in the city of Parsons on April 23 and in Belleville on May 18. Dr. Charles Rombold of Wichita, assisted in the Belleville clinic and Dr. C. B. Francisco of Kansas City, assisted in the Parsons clinic.

At the March 2 meeting of the Sedgwick County Medical Society held in Wichita, Dr. Earl C. Padgett of Kansas City, Missouri, spoke on "The Treatment of Burns," and Dr. R. M. Sorensen of the Venereal Disease Division of the Kansas State Board of Health, spoke on "Venereal Disease in Kansas."

The Wilson County Medical Society held a business meeting in Fredonia on May 3.

The Washington County Medical Society held a meeting in Washington on April 13.

The Wyandotte County Medical Society held a dinner meeting in Kansas City on April 20. Dr. Claude Dixon of the Mayo Clinic of Rochester, Minnesota, spoke on "Treatment of Common Diseases of the Colon." Dr. Dixon, a graduate of the University of Kansas School of Medicine, is an Associate Professor of Surgery in the University of Minnesota Graduate School at Rochester and Minneapilis.

DEATH NOTICES

Dr. Herbert Atkins, 62 years of age, died on April 10 at his home in Pratt. He was born near Louisville, Kentucky, on September 25, 1880, was graduated from the University Medical College of Kansas City in 1910 and served in the last war. Dr. Atkins was the Society Councilor for the Eleventh District and a member of the Pratt County Medical Society.

Dr. Archibald Grant Henderson, 78 years of age, died on March 14 at his home in Leonardville. He was born near Algia, Iowa, on June 13, 1864, and was graduated from the Missouri Medical College of St. Louis in 1899. He was a member of the Riley County Medical Society.

Dr. Winfred H. (Fred) Iliff, 59 years of age, died on March 2 at Baxter Springs. Dr. Iliff was born in the Indian Territory on December 15, 1883, was graduated from the University of Kansas School of Medicine in 1907, and served in the medical corps in the last war. He was at the time of his death the Secretary-Treasurer of the Cherokee County Medical Society which position he had held for many years.

Dr. George F. Zerzan, 64 years of age, died on March 22 in Salina. Dr. Zerzan's home was in Holyrood. He was born on August 23, 1878, in Schuyler, Nebraska, and was graduated from the Rush Medical College of Chicago, Illinois, in 1900, and served in the medical corps in the last war. He was a member of the Central-Kansas Medical Society.

OFFICIAL PROCEEDINGS

Due to lack of space some few reports were not printed in the April issue of the Journal, and are therefore printed at this time for those who were not able to attend the meeting at Topeka.

The following is the report submitted by Dr. Geo. M. Gray, Treasurer of The Kansas Medical Society:

TO: THE HOUSE OF DELEGATES:

Last year we began the year with a cash balance in the General and Defense Fund of $15,371.90. This year we begin with a cash balance in the Riverview State Bank of $16,481.73. There has been a constant improvement in our financial status over the past five years and in spite of a lessened income due to enlistment in the war effort by our members, yet our cash balance at the beginning of this year is the best of any year.

Last year I submitted a budget which in the first half of the year I thought would not amount to much but when we consider the expenditures for the full year I think it is of considerable value as indicating to the House of Delegates where their money is spent.

For instance the office rent has remained at a fixed amount. By changes in the office force the expenditure has been considerably reduced. The budget amount fixed for salaries was $8000.00 and this amount was reduced by $580.00.

Travel expense was fixed at $1000.00 and the actual expense was $817.57 not including travel expense of Delegates to the American Medical Association meeting. Last year expense for hotel and committee meetings amounted to $2,147.00. This amount was fixed in the budget for $1,450.00 but actually expended only $580.05. Social Security taxes were fixed at $350.00 and we actually expended only $156.35. In the defense fund last year the expense amounted to $1,716.00. Budget amount this year was fixed at $1,800.00 but we actually expended only $996.44, and of this amount practically all was as retainer fee of $75.00 per month.

Petty Cash fund expenditure last year $1,600.00. Budget figure $800.00. Actual expenditure this year in that fund was $2,100.00. Budget figure for this year $1,600.00, and in my opinion this figure should not be exceeded. Telegraph and telephone expense was fixed at $500.00. Actual expense in that fund was $873.72. Delegates' expense to American Medical Association for last year was $952.57. I have fixed the budget figure as $600.00 for the coming year. The total of this figure is $14,150.88 expended last year. I have fixed that amount in the budget figure as $12,740.00 for the coming year.

Your cash assets in my hands on April 30th, 1943, are as follows:

Cash Balance in the Riverview State Bank, are	$16,481.73
Cash Balance in Central National Bank of Topeka in Journal Fund is	889.10
U. S. Savings Bonds with a value of	8,600.00
Making a total of	$25,960.83

You also have a fund of about $1,500.00 in Dr. Tihen's hands which was obtained from special donations. In my opinion this money should be turned over to the Treasurer and kept in a special fund. I advise that it be invested in two per cent War Bonds which can be converted into cash whenever that money is needed.

Respectfully submitted

Geo. M. Gray, M.D., Treasurer

SUGGESTED BUDGET FOR PRESENT YEAR

LAST YEAR'S EXPENSE		APRIL 30, 1943 TO APRIL 30, 1944
Office Rent	$ 540.00	$ 540.00
Salary	8,027.84	7,500.00
Travel	817.57	900.00
Hotel Committees Expense	580.15	600.00
Social Security Taxes	156.35	200.00
Defense Expense	996.44	1,200.00
Petty Cash	2,100.00	1,600.00
Telephone and Telegrams	873.72	800.00
Delegates Expense A. M. A.	952.57	600.00
Total	$14,150.88	$12,740.00

The following is the report submitted by W. M. Mills, M.D., Editor of the Journal of The Kansas Medical Society:

TO: THE HOUSE OF DELEGATES:

The cost of the Journal during the past year has increased $233.63. The Journal paid back the loan of $343.90 made by the Society to buy paper stock. The profits for the year are somewhat less than last year, being $352.09. It was decided to reduce the size of the Journal eight pages because of the shortage of good scientific material and thus to save paper stock. The Board believes that the newly appointed committee chairmen might institute a plan of having each committee be reseponsible for sending at least one scientific paper to the Journal during the next year, preferably on a subject for which the committee is organized.

FINANCIAL REPORT
May 1, 1942 to May 1, 1943.

ASSETS:

Cash in Bank	$ 889.10	
Paper stock on hand	564.51	
Old Accounts Rec.	19.40	
April adv. acc. rec.	483.03	
P. O. Deposit & Stamps on hand	35.61	
		$1,991.65

LIABILITIES:

April printing bill, not rec. appr.	$ 257.75	
Surplus		$1,733.90

INCOME AND EXPENSE REPORT FOR PAST YEAR

INCOME

Advertising	$5,988.06	
Subsc. cuts, etc.	69.32	
Old accounts paid	162.66	
		$6,220.04

EXPENSES

Printing	$3,003.83	
Paper stock used	954.39	
Engraving	50.95	
Postage	285.00	
Salary	1,429.80	
Soc. Security—Victory Tax	40.50	
Stationery, supplies, ins., etc	103.48	
		$5,867.95
PROFIT		$ 352.09

Two places on the Editorial Board are vacant: that of Dr. L. E. Eckles who is now serving in the armed forces and that of Dr. R. B. Stewart who have moved to California.

The following is the report submitted by Robert Brooks, Executive Secretary:

TO: THE HOUSE OF DELEGATES:

My term of employment with The Kansas Medical Society to date has been short but extremely pleasant. To follow one so able and well versed in and devoted to his work as Clarence Munns, has indeed been a challenge.

Of the many duties, the one which has most recently received the larger part of my time and interest was concerned with the legislative session. I believe it to be of sufficient interest to you that I am going to attempt to present a short resume thereof.

Approximately thirty-five bills were introduced during the session, that pertained in some way to Public Health and medical care. Of these, the following were probably the most significant:

House Bill No. 25 providing for the temporary registration of nurses during the present war emergency was enacted.

House Bill No. 91 provided for the temporary admission to practice in this State, of physicians during the present war emergency. While this bill had merits recognized by many of the medical profession, it was permitted to die on the calendar because of the definite possibilities of its being amended by the cultists members in the House.

House Bill No. 92 creating a Board of Examiners for consulting psychologists and prescribing their powers and duties, was killed in the committee.

House Bill No. 120 provided that those registered or licensed to engage in or practice an occupation or profession at the time of their entrance into the military service, shall not have their license revoked or suspended for failure to re-register or non-payment of dues for six months after their military service. This measure affected all Kansas medical men in the armed forces, and was enacted.

House Bill No. 121 made more flexible the meeting date of the Board of Medical Registration and Examination for the purpose of examining applicants for licenses in Kansas. This act was meritorious in the light of the present accelerated medical school program and was enacted.

House Bill No. 138 providing for prenatal serological tests for syphilis died in the committee. However, House Bill No. 332 containing similar provisions plus a penalty clause, was enacted.

House Bill No. 139 providing for pre-marital serological tests died in committee.

House Bill No. 394 which was somewhat similar died on the calendar.

House Bill No. 189 provided for certain educational requirements for osteopaths. Although this bill contained a clause contended to raise their educational standards, it re-enacted the ostepoathic act of 1935 and might have been construed by a trial court to invalidate certain court decisions against the practice of medicine and surgery by osteopaths. This bill died in committee.

House Bill No. 204 provided for the payment of a salary of $10.00 per month to student nurses at the University Hospital at Kansas City, Kansas. This bill passed the House but was killed by the Senate in committee.

House Bill No. 273 providing for the creation and maintenance of joint boards of health by cities or counties was enacted.

House Bill No. 355 requiring the installation of improvements in plumbing which would tend to prevent epidemics such as the one experienced in Newton last fall was enacted.

House Bill No. 324 provided that when notified that the Norton Sanatorium is filled and patients are waiting for treatment, the State Board of Social Welfare may transfer patients from that Sanatorium to any public or private hospital in the State which will receive such patients and it was enacted.

House Bill No. 235 amended the General Statutes of 1935 pertaining to the admission of patients to the Norton Sanatorium and provided that health officers can designate the Sanatorium as a place of quarantine for tubercular patients endangering the public health. This bill was enacted.

House Bill No. 363 made aappropriations for the operation of several State Boards and Commissions during the fiscal year ending June 30, 1944 and June 30, 1945, and included in appropriation of $87,134.00 for the operation of the State Board of Health during these years. This can be compared with the $91,229.00 appropriation for the fiscal year ending June 30, 1942 and $84,679.00 for the fiscal year ending June 30, 1943.

Senate Bill No. 52 authorizing the State Board of Health to receive Federal grants was enacted.

Senate Bill No. 53 providing for compulsory smallpox vaccination and diptheria immunization for all school children under twelve years of age was killed in committee.

Three bills were introduced in the House which would have definitely permitted osteopaths to invade the field of medicine and surgery had they been enacted. The first—House Bill No. 40 provided for the setting up of a so-called composite Board of Registration and Examination composed of seven members not less than two of which should be osteopaths. The bill provided, however, that all applicants for license should be examined only by those members of the Board who are of the same school of practice as the aplicant claimed to be. In effect, graduates of a school of osteopathy who applied for license to practice medicine and surgery in Kansas would be examined only by osteopaths. The bill further provided that osteopaths be granted full license to practice medicine and surgery, not only in private practice, but in all State hospitals and institutions and make them eligible for any public office pertaining to public health or medical care. This bill died in committee.

House Bill No. 293 contained those provisions in Bill No. 189 reputed to raise the osteopathic educational requirements and also provided that osteopathic graduates be granted full rights and privileges in the practice of medicine and surgery in Kansas. This bill was reported out of Committee favorably and came up on the calendar early Tuesday, February 23. After a full day of debate the bill was killed by a motion to strike the enacting clause presented by Representative Donald Stewart of Montgomery County. The motion to strike was sustained by a vote of 60 to 40.

Although it was sincerely hoped that no further bills would be presented which would grant underserved privileges of practice to the cultists, House Bill No. 366 was reported out of Committee favorably and would have permitted osteopaths to administer and prescribe narcotics and biologicals. This bill remained well down on the calendar, but two attempts were made on the last day designated for consideration of House Bills, to declare an emergency, suspend the rules, and advance the bill to a place where it would have come to a vote. Although the osteopathic support of this measure had increased, it fell far short of the two-thirds vote required to advance it, and hence was lost.

The medical profession in Kansas should enter upon an aggressive educational campaign concerning the use of narcotics for many of the legislators and the layity do not realize how extremely dangerous they are in untrained or unscrupulous hands. The medical profession should further remove itself from the defensive to an offensive position as regards the standards of medical and surgical practice in Kansas.

Before passing from the legislative matters, I think it only fitting that tribute should be paid to your President, Dr. H. N. Tihen. No man could have given more freely of his time, money, and ability toward upholding the medical standards of our State. Though he admitted at first a lack of experience in legislative matters, he gave them unlimited amounts of time and serious study and functioned like a veteran. It was a twenty-four-hour a day job, as I can well testify. I would also pay tribute to Dr. Duncan, Chairman of the Public Policy Committee, and the twelve men who he and Dr. Tihen called upon to come to Topeka upon occasion to assist. A large share of the victory is due to them. I am also compelled to point out the tremendous amount of invaluable advice and the time



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and effort spent by Dr. Loveland. Few will ever realize how valuable and effective his efforts have been in the cause of Kansas medicine.

The next outstanding effort on the part of Kansas medicine with which I have been associated has had to do with military Procurement and Assignment. This job was well on its way to success before I came to Topeka. Late in the fall Dr. Loveland, Chairman, and his committee of advisers set up a series of meetings throughout the State at which a detailed survey of the doctor manpower of the State was made. These statistics were compiled into a report which was furnished to the National Procurement and Assignment Service. At the Seventh Corps Area Procurement and Assignment meeting in Omaha in December, this report was referred to as the Kansas Plan and it was suggested that because of the complete coverage and efficiency of the plan that it be adopted by other states. Many fine compliments have been paid to Dr. Loveland and his committee and Kansas medicine in general for the efficient manner in which Procurement and Assignment was conducted in Kansas.

At the present time a survey of all the doctors in the State is being conducted. Certain pertinent facts concerning each doctor are being assembled and each doctor in the State is receiving a classification number depending upon his age, number of dependents and essentiality to the community which he serves.

Through the initiative of the Industrial Medicine Committee wartime industrial hygiene clinics are being set up in Kansas City and Wichita which should be of great interest to the profession and should be widely attended by industrial leaders throughout the State. We have been most fortunate in the speakers that we have been able to secure. Most of them are men of national reputation in their respective fields.

Post-graduate activity has been renewed. The first of a series of sectional meetings is to be held in Emporia the 22nd and 23rd of this month. These meetings sponsored jointly by the Extension Division of the University of Kansas, the Kansas State Department of Health and The Kansas Medical Society will be on the subject of tropical diseases. Plans for other meetings commencing in the fall are being formed.

Many other committees have done a great amount of work but time does not permit a recounting of their excellent accomplishments.

During the past year the Society has enjoyed a close and most friendly relationship with the Board of Social Welfare, Board of Health, Commission on Revenue and Taxation, Division of Labor and Industry, Industrial Development Commission, The Highway Department, Attorney General's Office, Governor's Office, Kansas State Pharmaceutical Association, Kansas State Dental Association, Kansas State Chamber of Commerce, and many other fine organizations. The continued assistance and cooperation of the State Board of Health has been most helpful.

Kansas men of medicine have done an excellent job in staffing the examining boards for selective service. Our office has enjoyed a most happy relationship with Lt. Col. Seth Hammel in this work.

There are listed on our records 1,046 paid members with less than a hundred delinquents. In addition there are approximately 380 members in the armed forces. The expenditures for the Society for the past year are as follows:

GENERAL FUND

Salaries:		
Regular	$6,992.13	
Extra	446.50	
		$ 7,438.63
Office rental		540.00
Telephone and telegraph		873.81
Postage and express		386.85
Stationery and supplies		902.84
Travel		1,144.13
Committee expense		1,419.46
Journal loan		343.90
Social Security		176.35
Procurement and Assignment		325.90

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FRACTURES & TRAUMATIC SURGERY—Two Weeks Intensive Course starting June 14 and October 18.
GYNECOLOGY—Two Weeks Intensive Course starting June 28. One Month Personal Course starting AUGUST 2. Clinical and Diagnostic Courses.
OBSTETRICS—Two Weeks Intensive Course starting October 4.
OPHTHALMOLOGY — Two Weeks Intensive Course starting September 13. Course in Refraction Methods October 4.
OTOLARYNGOLOGY—Two Weeks Intensive Course starting September 27.
ROENTGENOLOGY—Courses in X-ray Interpretation, Fluroscopy, Deep X-ray Therapy every week.
UROLOGY—Two Weeks Course and One Month Course available every two weeks.
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State meeting	685.35
Military refunds	212.50
Miscellaneous	278.87
	$14,728.59
Defense Fund:	
Expense	$ 996.44
	$15,725.03

At the time of my coming to Topeka October 1, 1942, Miss Jane Skinner was Assistant Executive Secretary and Miss Miriam DuMars was ably assisting. Early in December Miss Dumars tendered her resignation in order to take up journalistic work and Mrs. Margaret Foster who had had experience in the office accepted Miss Dumars position. Early in February Miss Skinner resigned her position. The services of Mrs. Rosaleigh Barney have been secured. I cannot speak too highly of the loyalty and efficiency of these valuable helpers.

Mrs. Mateel Todd shares our office quarters in her capacity as business manager of the Journal.

In closing I want to tell you how much I have enjoyed working for you during the past seven months. Many of the activities were entirely new to me, but kindness and patience and generosity has made every moment a pleasure. There are a number of you that I have not been able to get acquainted with personally. I sincerely hope that the next few months will change this. We in the central office are happy to be working for you and we want you to use us at every opportunity. These are trying times and the doctors of the State of Kansas are burdened. If this Society can assist you in any way, please let us know.

The following report was submitted by George E. Milbank, M.D., Chairman of the Committee on Allied Groups to Medical Practice:

TO: THE HOUSE OF DELEGATES:

The Committee on Allied Groups to Medical Practive of the Kansas Medical Society deals with many controversial subjects including all of the cults. In view of the fact, that the Committee had rather thoroughly discussed the subjects, which were on its agenda, and that the osteopathic bill and other disputed measures were coming before the Legislature, it was deemed wise not to actively push many of the measures, which the committee had previously proposed especially those dealing with a number of the cults. Hence it was thought that there was not enough new business or urgent old business to come before the Committee, which would warrant a formal meeting necessitating time and travel by a number of the busy committee members.

While the Committee for the above reasons has been relatively inactive this year, we have considered some measures, which should be studied and acted upon by next year's committee.

We believe that further efforts should be made to adjust some of the inequities in the Kansas Crippled Children's law and its interpretation by the Crippled Children's Commission. Mr. Munns made a rather active effort to obtain payment for anesthetists, radiologists and clinical pathologists for services rendered under the Crippled Children's Act, but up to the time of his induction into the Army, no action had been obtained. Further efforts should not be stopped.

CLASSIFIED ADVERTISEMENTS

FOR SALE OR RENT—Equipped office, four-room building, for general practice in town of 1,400, south-central Kansas, for sale or rent. Write for details to T. J. Thomas, M.D., Veterans Administration Hospital, Waco, Texas.

FOR SALE— Entire ultra-modern medical equipment of the late Dr. Harrison B. Talbot for sale—Address Journal of The Kansas Medical Society, C-03. Mrs. H. B. Talbot, 600 West Eleventh Street, Apt. No. 6, Topeka, Kansas.

FOR SALE—Office equipment of retiring physician engaged in general practice including complete line of instruments, instrument tables (2), sterilizer, anesthesia table, sterile cabinets, irregator stand, centrifuge. Everything in the best of condition. Write C-O—6% the Journal.

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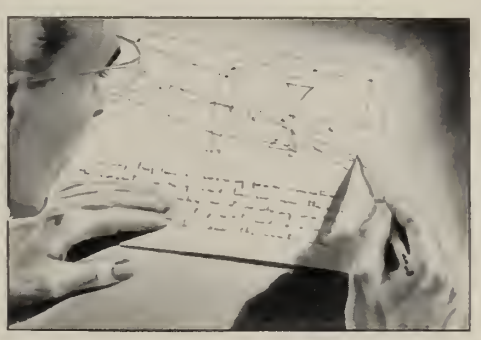
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The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

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NED R. SMITH, M.D.
Resident Medical Director

We would recommend, that further steps be taken to study the practice of psychiatry by psychologists obtaining the assistance of the Kansas Psychiatric Association in this study.

The committee again wished to point out value of a medical examiner law as contrasted to our present Kansas coroner law, and to recommend that further steps be taken to obtain this needed reform.

We recommend that further study be made of the eight hour day for nurses with a report as to its effect on the profession and the public, as well as the nurses themselves.

We feel that the Cosmetology law should be revised, and as soon as the legislative committee feels that it is timely to do so, an effort should be made to limit the field granted to cosmetologists by the above law.

The following report was submitted by Charles Rombold, M.D., Chairman of the Committee on Industrial Medicine:

TO: THE HOUSE OF DELEGATES:

At a well-attended meeting in Wichita on November 7, 1942, Dr. Olin J. Johnson of the Council on Industrial Health, American Medical Association, gave a most informative address on the requisities and functions of an industrial health program. Plans were made for an industrial health clinic to be held in Wichita on March 20, immediately subsequent to a like meeting in Oklahoma. Committee members participating in the formulating of these plans were: Charles Rombold, M.D., Chairman, James L. Beaver, M.D., C. E. McCarty, M.D., J. R. Betthauser, M.D., C. E. Kassebaum, M.D., A. E. Hiebert, M.D., R. M. Heilman,

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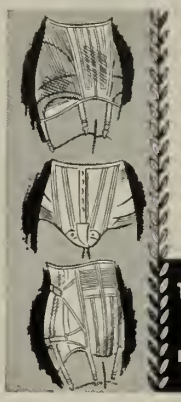
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M.D. and C. H. Benage, M.D. Due to our inability to secure the services of a sufficient number of these speakers, the meeting was postponed.

A second meeting was held in Wichita in April. Revised plans are now nearing completion for an Institute of Wartime Industrial Health to be held in Kansas City and Wichita, on June 3 and 4, which will be addressed by a group of nationally-known specialists.

The following is the report submitted by Philip W. Morgan, M.D., Chairman of the Committee on Study of Heart Disease:

TO: THE HOUSE OF DELEGATES:

The past year has seen the least activity in this Committee since its creation several years ago. A post graduate refresher course had been arranged for the fall of 1942 with Samuel A. Levine, M.D., of Boston, as the instructor, but due to the war emergency, Dr. Levine has asked to postpone the course until things are less rushed.

During the past year the Missouri State Medical Society has created a Committee for the Study of Heart Disease and has patterned its program and activities after the Committee in Kansas. In an editorial in the Missouri State Journal, credit was given the Kansas Committee for the stimulation it had given the physicians of Missouri.

It is hoped that the various county medical societies over the State who would like information concerning speakers on cardiovascular subjects will communicate with the members of this Committee, since one of its activities is to maintain a list of subjects upon which various men have arranged talks which they prepared to present to any society wishing them.

It is also hoped that continued wider use of the book entitled: "Nomeclature and Criteria for Diagnosis of Diseases of the Heart", copyrighted by the New York Tuberculosis and Health Association, Inc. and adopted and distributed by the American Heart Association of 1790 Broadway, New York City will be more widely used.

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The following is the report of O. W. Davidson, M.D., Chairman of the Committee on Venereal Disease:

TO: THE HOUSE OF DELEGATES:

Following the death of Arthur D. Gray, M.D., of Topeka, I was asked to assume chairmanship of this Committee. Since the activities he had outlined for the year were in operation no further meetings were held, and no changes made in his program. The work of the Committee covered various phases of the venereal disease problems as influenced by the war time emergencies. The Committee is grateful for the assistance of the Director of Venereal Disease Control of the Kansas State Board of Health.

ANNOUNCEMENTS

The central office has received information that the Department of Obstetrics and Gynecology of the University of Nebraska College of Medicine will present a symposium on obstetrical analgesia and anesthesia at the University Hospital, Forty-second and Dewey Avenue in Omaha, Nebraska, on May 28, 1943, in cooperation with the Nebraska State Medical Association and the Division of Maternal and Child Health of the State Department of Health. Guest speakers who will appear on the program are as follows: Dr. F. S. Hartmen, Pathologist of the Henry Ford Hospital of Detroit; Dr. R. A. Hingson, Anesthetist of the United States Public Health Service of Staten Island, New York; Dr. N. R. Kretzschmar, Associate Professor of Obstetrics and Gynecology of the University Hospital of Ann Arbor, Michigan; and Dr. A. H. Parmalee, Associate Professor of Pediatrics of Rush Medical College of Chicago, Illinois. Address communications for further information to Dr. Willis E. Brown, University Hospital, Omaha, Nebraska.

The following abstract from a recent letter received by one of our editors from a surgical friend in London may prove of general interest:

"Consulting medical practice has also suffered greatly in London; this has not been from overcrowding as in your case, but from migration of a large proportion of well-to-do people out into the country and the fact that people no longer wish to come up to London for consultations and as a result the specialists in the country who are not in the army are in some places doing very well indeed.

"Even before the war the standard of surgery especially was becoming very high in the provincial towns and it was becoming increasingly difficult to earn a living as a consulting surgeon. In the future I think it highly probable that Harley Street will almost go out of existence; all consulting rooms will be attached to hospitals where there will be facilities for private patients, and nursing homes will cease to exist. This was already coming in before the war. Staffs of hospitals will receive salaries which will at any rate enable them to live rather than have to scramble for money in a ceaseless competition which ruins a young man's change of doing really good work.

"One hears a lot about state medicine at present, but I doubt if it will come entirely into being, although the hospitals will undobtedly be more state-aided and the staffs will be more adequately rewarded for their work than in the past."—Archives of Physical Theopy.

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32. 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

KANSAS MEDICAL ASSISTANTS' SOCIETY

The fourth annual convention of the Kansas Medical Assistants' Society held in Topeka, May 16, 1943, was small compared to past years attendance, but was one of the most enthusiastic meetings yet held. There were sixty-eight registrations.

Lt. Roy Anderson of the Winter General Hospital of Topeka, was the only guest speaker for the meeting which was necessarily streamlined because of existing conditions. The luncheon was held at the Kansan Hotel with Dr. C. O. Meredith, State Medical Councilor, of Emporia and Dr. A. J. Brier, President of the Shawnee County Medical Society, as guests.

At the business meeting immediately following the luncheon the Society voted to appropriate $100.00 toward furnishing a Sun Room for Winter General Hospital. A motion was made and carried to "hold" this fund temporarily to permit local society and individual contributions to be sent in to put with it in an attempt to raise the amount to $250.00, the sum needed to completely furnish one room. All contributions should be sent to the chairman, Mrs. Florence Linton, Mills Bldg., Topeka, Kansas. Also at this meeting the amendment to the by-laws was passed by unanimous vote. The amendment reads as follows: Chapter 3, section 3, "That the annual nomination and election of officers shall be held at a meeting following the luncheon of the maain day of the meeting."

To complete the days program a tour of the Winter General Hospital was conducted by Lt. Anderson.

The new State officers for 1943-1944 are:

Mrs. Edna Nichols, President Hutchinson
Miss Bessie Parker, President-Elect Emporia
Miss Margaret Parrott, Vice-President Wichita
Mrs. Faye Bullard, Recording Secretary Hutchinson
Miss Irene Miller, Treasurer Emporia

The Councilors for 1943-1944 are:

First District, Mrs. Florence Linton Topeka
Second District, Mrs. Margaret Provost, ... Strong City
Third District, Miss Mary Nicholson Winfield
Fourth District, Miss Marie Patterson Ellsworth
Fifth District, Miss Margaret O'Rorke Dodge City

The Medical Advisory Council as announced by Dr. Lattimore, President of The Kansas Medical Society, are as follows:

Dr. C. O. Meredih, Chairman Emporia
Dr. L. B. Spake Kansas City
Dr. C. D. Blake Hays
Dr. F. L. Menehan Wichita
Dr. Harry J. Davis Topeka

MEDICAL ASSISTANTS' NEWS

At a recent meeting of the Lyon County Medical Assistants' Society the following new officers were elected: President, Miss Margaret Griffithe of the Newman Hospital of Emporia; Vice-President, Miss Marjorie Finley of the Newman Hospital of Emporia; Secretary, Mrs. Overta Skinner, Gazetts Bldg., of Emporiaa; Treasurer, Mrs. Margaret Provost of Cottonwood Falls.

The Reno County Medical Assistants' Society held a dinner at the Wiley Tea Room in Hutchinson on April 13. The following officers were elected for the coming year: President, Mrs. Blanche Roulier; Vice-President, Mrs. Margaret Eaton; Secretary-Treasurer, Mrs. Faye Bullard. The word study for the meeting was on the bones of the extremities, which is a regular part of the program and one that is quite beneficial to the members.

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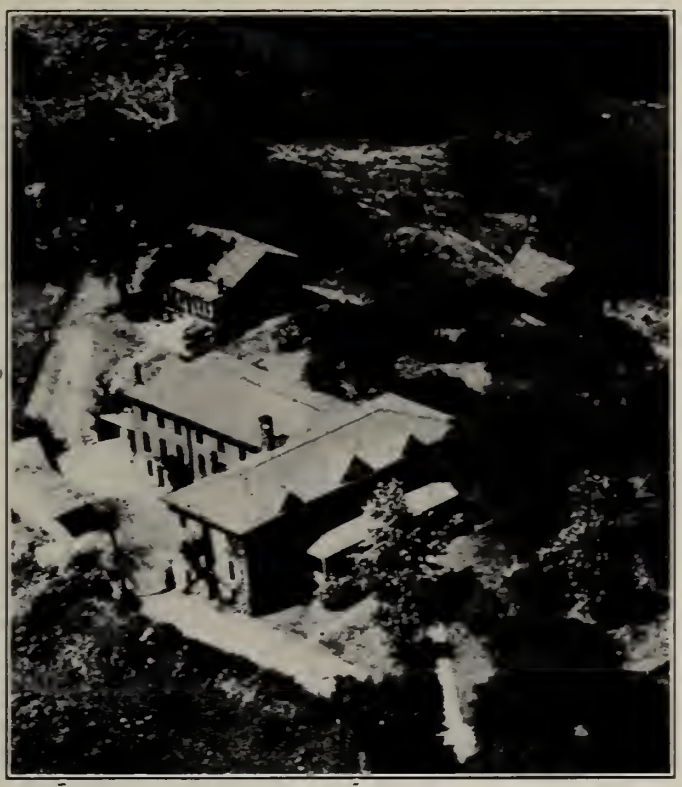
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MRS. LEO J. SCHAEFER, Salina.....President-Elect
MRS. C. D. BLAKE, Hays.....First Vice-President
MRS. M. A. BRAWLEY, Frankfort....Second Vice-President
MRS. H. L. REGIER, Kansas City, Kansas.....Secretary
MRS. E. N. ROBERTSON, Concordia.....Treasurer

PRESIDENT'S MESSAGE

The coming year may be difficult and our activities will be curtailed in many ways, but there is a great deal we must do.

There is a crying need for more man power. Women are being called upon to take the places of men so they can be released for military service. This requirement is taking



MRS. E. E. TIPPIN
PRESIDENT

mothers from the homes and a juvenile delinquency is developing, especially in defense centers, that is alarming. Each member of our Medical Auxiliary has a responsibility to inform herself concerning conditions in her locality, and to help correct certain situations. We can not do this as an Auxiliary but as individuals cooperating with other organizations interested in the morals of our young people.

These are difficult and anxious times for wives and mothers in our Auxiliary who have loved ones in the service. Let us lend any assistance to them that is possible. Keeping in touch with them in some way such as sending notice of meetings, bulletins, or friendly letters.

Let us not neglect the soldier who may be stationed near our city. Many conditions should be corrected to make his surroundings wholesome. We would want as much done for our sons. He has been placed in a strange world, probably he is young and homesick. In helping him to make a happy adjustment we are helping in the defense of our country. Probably there is an agency already in the defense of our country. Probably there is an agency already organized for this purpose that needs your assistance, if not, why not form one?

It seems in a democracy everyone should realize their responsibility as an American citizen. We have seen what has happened to Europe for its complacency and there are forces at work in our country to take away our liberties; yet many American women will not take the trouble to go to the polls to vote. Your Auxiliary President wishes our Auxiliary to be one hundred per cent loyal Americans by being one hundred per cent voting American women.

Never before have we needed to focus our attention on health as much as now. Problems in adequate nutrition will arise more and more as the war continues and our labor and transportation difficulties develop. It is our responsibility as Auxiliary members to fully inform ourselves and take our rightful place as leaders in health education in our respective communities.

Sincerely,

Mrs. E. E. Tippin

AUXILIARY NEWS

The March meeting of the Women's Auxiliary to the Sedgwick County Medical Society was held in Wichita at the Lassen Hotel. Mrs. W. J. vonWormer, Jr., President of the Wichita Garden Club spoke on "Victory Gardening". At the April meeting of the organization the following were elected to office for the coming year: Mrs. Rene Gouldner as President-Elect; Mrs. Leslie Knapp as Vice-President; Mrs. Frank Emery as Corresponding Secretary, Mrs. E. C. Rainey as Recording Secretary; and Mrs. John Kleinheksel as Treasurer. Mrs. W. P. Callahan the new President and the other officers were installed at the May 4 meeting. The Wichita Auxiliary recently purchased a $25.00 war bond.

At a meeting of the Central Kansas Medical Auxiliary held in Hays in March the following new officers were elected: Mrs. Fagan N. White of Russell as President; Mrs. George Penwell of Russell as Vice-President; Mrs. Otis True of Hays as Secretary and Mrs. George F. Davis of Kanapolis as Treasurer. The next meeting of the organization will be held in Russell in June.

"WHICH AM I?"

Are you an active member, the kind that would be missed?
Or are you just contented that your name is on the list?
Do you attend the meetings, and mingle with flock,
Or do you stay at home and criticize and knock?
Do you take an active part and help the work along?
Or are you satisfied to be the kind that "just belong"?
Do you ever go to visit a member who is sick,
Or leave the work to just a few and talk about the clique?
So come to the meeting often and help with a hand and heart—
Don't just be a member but take an active part.

From the West Virginia Club Woman.

The per capita consumption in the United States of milk and eggs is low—of refined sugar, the highest in the world. —Bulletin of the National Tuberculosis Association.

The Journal Of
THE KANSAS MEDICAL SOCIETY
Owned and Published by The Kansas Medical Society

Volume XLIV JUNE, 1943 Number 6

EULOGY TO GENERAL FRANCIS ANDERSON WINTER*

Lt. Col. Waldo B. Farnum

Topeka, Kansas

We are met today in a truly dedicatory sense. This great hospital, constructed and activated for the purpose of caring for the sick and wounded of our armed forces, stands as a monument to those whose thought, planning and performance have conceived a structure of this magnitude and professional caliber.

Unfortunately, such thought and planning will have proved necessary for indications are that the forty-three general hospitals in the zone of the interior will be more than full as more and more of our soldiers take the offensive in this most gigantic of struggles. How fitting, that these general hospitals should bear the names of men who have served their country in times past! How fitting, that our memories of them should be kept alive in such a truly constructive manner!

What a tribute to have one's memory associated with such attributes as solace, comfort, kindness, ease of pain, and the restoration of health!

Sitting with us today is one who shared and I dare say contributed much to the service of the medical officer whose name this great hospital is to take. Her memories today are her own, but may we share these memories; and, I trust, her pride for a moment or two.

Gen. Francis Anderson Winter was born at St. Francisville, Louisiana, on June 30, 1867, of parents well qualified to produce a distinguished son. His preparatory school education was accomplished at St. Louis. After spending two years at Bethel Military Academy in Virginia he entered the St. Louis Medical College, receiving the degree of Doctor of Medicine in 1889. He was appointed Assistant Surgeon in the United States Army in 1892. From then until his death in 1931 General Winter's efforts were directed toward the more efficient and more humane handling of the sick and wounded of the Army both in time of peace and time of war. His record of service and achievement is long and bright. His first assignment was with the Seventh Cavalry then stationed at Fort Riley, Kansas: How in keeping that a hospital here in this State should honor him.

As a young medical officer he served with the Second Cavalry at Fort Wingate, Navaho Country; the International Boundary Commission at Yuma, Arizona; at Fort Hancock, Texas; at Fort Grant, Arizona (again with the Seventh Cavalry). As a Captain stationed at the United States Military Academy, West Point, New York, he married, in 1897, Mary Davenport Smith of West View, Virginia, who graces us with her presence today.

In the Spanish American War Captain Winter went to Cuba serving with the Cavalry Division, Fifth Army Corps. Later he was sent to Manila with the Twelfth Infantry and for gallantry in action was recommended for the Brevet of Major during the Philippine Insurrection. (He accomplished in all, three tours of duty in the Philippine Islands.) He was the Commanding Officer of the Army and Navy Hospital at Hot Springs, Arkansas in 1916.

As a Colonel in the First World War he was sent to France by General Gorgas and there undertook the heavy burden of organization of the Medical Service of the Service of Supplies, holding the title of Chief Surgeon, Base and Lines of Communication, American Expeditionary Forces. The manner of his performance of this trying task brought these words from General Ireland: "Colonel Winter is one of the distinguished members of the Army Medical Corps, who has done much more than his share in carrying its burdens for the past thirty years. He not only is an accomplished physician and surgeon, but is a scholar, a man of charming personality and an excellent administrator. He helped to bear the responsibility of the medical department in the Santiago Campaign, in the Philippine Insurrection, and in the World War. He went to France before the lines of communication were organized and became the surgeon of this important activity. By his great administrative ability and his vision for the

*Presented at the dedication services of the Winter General Hospital on May 22, at Topeka, Kansas.



Aerial view of Winter General Hospital (photo taken by U. S. Army Air Force, Topeka, used by special permission).

future he made possible the splendid medical organization developed in the lines of communication. After the consolidation of the activities in France and the establishment of the Service of Supply, Colonel Winter went to England where the medical department had apparently not been able to get started and by his energy and fine professional and administrative qualities accomplished in this section one of the finest pieces of work done by any medical officer during the War."

General Winter's work in France and England won him the Distinguished Service Medal with the following citation: "For exceptionally meritorous and distinguished service in a position of great responsibility. As Chief Surgeon of the Lines of Communication, American Expeditionary Forces, from June to December, 1917, he organized medical units at the base ports and camps in France. He established large supply depots from which medical supplies were distributed to the American Expeditionary Forces, and by keen foresight and administrative ability made these supplies at all times available to our armies."

France made him an Officer of the Legion of Honor and King George V of Great Britain created him a Companion of the Most Honorable Order of the Bath.

After the World War, General Winter held a number of assignments, one of the most important being Librarian of the Army Medical Library of Washington, the largest collection of medical books the world has ever known.

General Winter died in the Walter Reed General Hospital, Washington, D. C., on January 11, 1931, and at the time of his death his long-time friend, Brigadier-General Jefferson Randolph Kean, one of

the Army's most brilliant men, said; "While his friends recall his professional and military career with pride, it is for his social gifts and personal qualities that they will always love his memory. With the fine scholarship which had its roots in a good classical education, he had a merry humor and a gift of lively and witty conversation that made him the central figure in every social group in which he was present. With all his social charm and loyal devotion to his friends, his virile and impetuous spirit has no toleration for slackness in duty or incompetence in official administration."

These two quotations, coming as they do from General Winter's contemporaries and fellow workers, bring his memory very close to us today. May the endeavor expended here do further credit to it! It is with great pride that we serve this hospital bearing the name of so distinguished and loved an officer of the Medical Corps of the United States Army.

This is truly your hospital—a fact which I hope will not be brought home to too many of you too soon!

FUNDAMENTALS OF PSYCHIATRY IX

THE THEORY OF THE UNCONSCIOUS

William C. Menninger, M.D.

Topeka, Kansas

When an individual is well and healthy he usually believes that he knows why he does all that he does. Sometimes, however, his explanations for his attitudes and behavior are so shallow that he himself may question their validity. Occasionally he may admit that he doesn't know just why he did a certain thing, or why he takes a certain point of view. This problem of understanding human behavior becomes very complex for the average layman who may see a mentally sick person with delusions or hallucinations; then he is at a total loss to explain why or how the individual developed such symptoms. The psychiatrist, too, would be at a loss to explain such behavior in a man unless he makes use of a theory that there is one part of the individual which seems to be under voluntary control, and a larger part which is not under voluntary control. There is a sort of Dr. Jekyll and Mr. Hyde arrangement in every person, though not necessarily with one part "good" and one part "bad." This unknown strange and irrational part of each individual is termed the "unconscious," a scientific hypothesis to explain otherwise incomprehensible phenomena.

By definition the "unconscious" is a large region of the mind which is inaccessible to conscious awareness by ordinary means of questioning or self-examination. In it are contained the inherited and racial trends. Man is the result of a long evolution, and the very fact that he walks upright and that he has certain methods and purposes in the use of his hands, facial expressions, and speech and many other characteristics are all the result of inborn racial trends. In addition to these trends one must recognize certain tribal features which are inherited. For instance, the fact that a person may be a member of the Jones family determines many of his physical as well as psychological characteristics, and differentiates him from a member of the Smith family. So all of us inherit certain definite characteristics from our immediate family line. These are all included in the unconscious.

The region of the mind which we call the "unconscious" also contains the primitive, forbidden strivings. In the very small infant they are not forbidden, so he finds gratification by direct expression without restraint and without modification of his methods. But as the child grows up the two original primitive energy drives of love (libido) and hate (aggression) have to be molded and cloaked and controlled. Their sources, however, remain in this deep unconscious region.

Finally, this region contains the forgotten incidents of infancy and early childhood as well as all the associations established at that time.

THE EVIDENCE OF THE EXISTENCE OF THE UNCONSIOUS

One cannot prove conclusively that there is an "unconscious"; it cannot be demonstrated like the brain. It is not an anatomical unit. It is not subject to mathematical proof. Nevertheless, there is a great deal of evidence which points to the existence of some part of the personality which is inaccessible to one's conscious wish or desire either to control or to investigate.

1. Observations During Hypnosis.—By the particular psychological device known as hypnosis, an individual can readily be placed in a trance-like state, entirely subject to the control of the hypnotist. In this state of mind an individual may recall incidents or remember facts that he is not able to recall in his normal state of mind. It is assumed that they reside in this hinterland, the unconscious. Even more convincing is the fact that during this trance the individual is especially susceptible to suggestions, and the hypnotist can make suggestions to him which he carries out after he comes out of the hypnotic state, without recalling that these acts were suggested to him. In such instances, one is certainly

dealing with a region of the personality which cannot be reached during the alert, wide awake, "conscious" state.

2. Dreams.—Practically every one at some time or other has dreams. The layman regards them as nonsensical and meaningless, and usually forgets them promptly on awakening. Nevertheless, one must recognize that they are thought processes which are creations of the particular individual. They have some significance and some relationship to other thought processes that go on in his mind. The fact that he doesn't understand them is of importance because through psychoanalysis we have learned that the dream itself occurs in a nonsensical, queer, or bizarre form for a purpose. A dream expresses a wish, a wish which the conscious does not want to accept, and for all intents and purposes will not recognize. The dream is a production of the unconscious part of the mind, which, however, is censored and forced into a disguise by the conscious part.

3. "Slips" of Speech.—Every individual has been in certain situations in which he has made "slips" of the tongue. Often these are exceedingly embarrassing. He may believe that he wants to be very polite or very gracious or hospitable, but much to his own embarrassment he makes some "slip" of the tongue indicating an ungracious or inhospitable or impolite attitude. Such slips of the tongue can be explained only by the fact that the individual has contrasting wishes; consciously he wants to be polite, or may feel that he must be polite, but wishes unconsciously to be the opposite. So in an unguarded moment when the conscious censor of the personality is "off duty" the slip of speech occurs. The conscious thinks one way and the unconscious acts the other.

4. Childhood Experiences.—Even to the layman it may be a puzzling fact that rarely does an adult recall any particular impressions or relationships or very clear-cut memories prior to his fifth or sixth years. All of us may recall a few memory pictures of certain situations,—"mother playing at the piano" or of some incident which because of its unusual character we recall questionably as a memory or because it was repeated as a story throughout childhood. Most of the facts, however, as to how one learned to be honest or kind or thoughtful, or how one learned to have temper tantrums, to be impatient, or to prefer seclusiveness, are all forgotten. The most formative period of an individual's life, namely, the first six or seven years, becomes a blank. These memories fade from conscious recognition.

Most individuals take the attitude that they know themselves very well. They think they know why they do everything and can explain the purpose of all their behavior and attitudes, and yet it is common (though ignored) knowledge that all of us are well formulated as to our reactions, our habits, our relationships, during a period which none of us can recall. What happens to these memories? They are still influential in our lives. They have considerable power, and yet they are beyond recall. These, too, have gone to make up this other part of the personality which is inaccessible by any ordinary means to conscious awareness—the "unconscious."

5. Psychotic Speech and Behavior.—In those individuals who develop psychotic reactions one can observe in their speech and behavior evidences of the unconscious. In perhaps every instance we cloak ourselves in a thin veneer of civilization and training and appear in our best social behavior. In the psychotic person this veneer is wiped away. It is as if we could see the deeper layers of the personality in a nude state. Any psychiatrist can cite many examples of psychotic behavior in which the primitive nature of the personality stands out. The individual who in normal life was very particular about his personal appearance, very clean and very neat, may go to the other extreme in his psychosis and be dirty, slovenly, and gain as much obvious satisfaction as he did in being the opposite. Likewise, the individual who was very thoughtful and polite, very gracious, may become very disagreeable, perhaps vulgar, impolite and even combative in his psychosis. In both instances, we can see that the expressions are extreme opposites, and one must assume that in conscious life the individual unconsciously makes an extra effort to be neat and polite so that he may keep under control the strong desires in his unconscious to be untidy and aggressively disagreeable.

6. Forgetting.—Most of us forget most of the things that happen to us, unless for some special reason they register in our memories. Yet nothing happens to us which does not leave an impression upon us. No memory is every entirely forgotten. It merely fades from accessibility to the conscious recall.

Every person has the experience of knowing a person's name, or the name of a place, and perhaps knows it very well, but momentarily cannot recall it. Usually if one makes a special effort to recall it, he is still unsuccessful in recalling the name. Then perhaps an hour or two later when he is not attempting to recall it at all the name comes to mind. Where has it been in the meantime? On the basis of the hypothesis of the unconscious, it is in an upper layer of the unconscious, an area termed the preconscious. The very fact that it retreats when one makes a special effort to recall it is further evidence of the presence of the unconscious. Through psychoanalysis, it

is often possible to demonstrate that in such instances, because of some unpleasant association, we do not want to recall the name or place. These dislikes form barriers which seem to be increased when the conscious effort is made to recall it.

7. Unexplained Solution of Problems.—Most of us have the experience of trying to work some kind of a problem, or trying to gain or recall some idea. We may deliberate and think about it a great deal and come to no solution. Then we leave the subject unsolved. Perhaps the next morning on the moment of wakening the light seems to dawn and the problem is solved and seems very simple. The idea or the decision is crystallized very definitely and positively—thus the meaning of the expression "I want to sleep on it." One can explain such an experience only on the basis that there is an unconscious mental activity, a mental activity that goes on beyond the conscious awareness even of its existence.

8. Small Amount of Conscious Material.—From one point of view man's mind is always one-tracked. We think of only one idea at a time; consciously, we can recall many other things, the experiences of a fishing trip ten years ago, an incident in early school life, an association with an old friend, how to compute square root, but at any one moment all of these other ideas, thoughts, and memories, are excluded from awareness. These memories are not in the unconscious because they are accessible when we attempt to recall them. There is an element about the memories, however, which is unconscious, namely, the relationship of one to the other. For example, the average man's attitude and relationship toward women is fundamentally dependent on the experiences and the patterns of reaction which he formulated toward his mother, the only woman who really figured in his life for the first six or eight years. All subsequent contact with women is in some degree dependent upon the pattern formed in these first years. Thus, the individual may recall various experiences with women, various love affairs, various experiences with his wife. Even though he attempted to correlate these with the experiences or reactions toward his mother, he would be unable to do so. Thus, the relationships between the various memories are inaccessible to investigation by any ordinary means.

THE CHARACTERISTICS OF THE UNCONSCIOUS

In the discussion of the evidences of the existence of an unconscious we have given some of the characteristics of this region of the mind, though not all.

1. The Dynamic Nature.—The unconscious is regarded as being a powerful force in the life of every individual, and not as an inert group of discarded experiences or associations. The unconscious contains the primitive emotional drives of every individual. As he becomes an adult these must be cloaked, modified, civilized, but nevertheless, the force of the drive always arises from the unconscious.

2. Infantile Nature of the Unconscious.—As we can judge from the expressions of the unconscious in psychotic individuals, in dreams and in other forms, one is impressed with the fact that it never grows up. The unconscious is always infantile and primitive in its nature. It is the source of the two chief energy drives, one of which is to seek gratification which is predominantly sexual, and the other, the aggressive or destructive drive. These are often contrasted as the impulses toward love and toward hate, or toward construction and toward destruction. Technically, they are termed the "erotic" and the "aggressive" drives. When the individual's modifying faculty is disturbed by sickness, as a result of imbibing alcohol, or from any other cause, one can see the primitive animal-like nature of these two drives.

3. Repression.—The unconscious has its origin partly because of the demands placed upon every individual, first by his parents and later by the world and civilization. As he grows up these primitive drives cannot be expressed directly but must be held in check. They are held in check by forces within the personality which permit their escape only in modified forms which are socially approved. This force is called "repression," and as a result of repression the unconscious necessarily increases in size because so many of the wishes cannot be expressed—they have to be repressed. One might presume that if an individual grew up in a Garden of Eden where no demands were made upon him he might have no need for a differentiation between "conscious" and "unconscious." He would need to have no repressions except for his own self-preservation. But in all civilized men the unconscious is in part the result of repression.

4. Timelessness.—The unconscious has no sense of time. It contains powerful forces, which continuously demand expression and seek it in every possible form. It makes no difference whether the individual may be five or fifty years of age, the demands are essentially the same.

5. Illogical Character of the Wishes.—The unconscious is illogical. The primitive urges or desires as we can see them have no sense in terms of conscious logic. There is, however, no contradiction between the two drives within the unconscious. Both are positive in nature.

6. The Pleasure-Pain Principle.—As has been discussed in a previous chapter the infant goes on the life principle of seeking pleasure and gratification

in every form that he can find, and of avoiding pain and frustration. The unconscious operates on this principle. It is isolated from the world of reality and pays no attention to the demands of the external world. It is left to the conscious part of the individual to modify the primitive pleasure-seeking drives so that they conform to the demands of the external environment.

7. The Non-Verbal Nature.—The unconscious does not express itself in words, nor does it attempt to verbalize ideas. It expresses itself through forces, through power directed toward the achievement of certain desires. These forces might be compared to the mainspring of a jumping-jack. As long as the lid is closed, by repression through the strength of the conscious life of the individual, they never appear although they are always under tension and have potential force. The moment that the conscious life weakens, whether it be in sleep or in mental sickness or intoxication, the lid may open and the powerful spring of desire expresses itself directly to the world.

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According to the 1942 Directory of Medical Specialists, published by the Columbia University Press, there are 18,163 physicians in the United States and Canada working in fifteen specialized fields of medicine. Of these, the greatest number, 2,971, are otolaryngologists, or specialists in disorders of the ear and throat; the smallest number, 107, are neurologic surgeons. Practitioners of internal medicine are second in number, with 2,604; ophthalmologists, or eye doctors, numbering 1,759, come third; and surgeons, with a total of 1,719, are fourth. The fifth largest group, comprising 1,638, specialize in radiology, or treatment by x-ray and radioactive substances. Plastic surgeons, next to neurologic surgeons, are the least numerous, and total 124.

Other branches listed, and the number of specialists in each, are as follows: pediatrics, or children's diseases, 1,633; obstetrics and gynecology, 1,396; psychiatry and neurology, 1,202; pathology, 818; urology, 748; orthopaedic surgery, 734; dermatology and syphilology, 568; anesthesiology, 142. —New York State Journal of Medicine.

A physician may possess the science of Harvey and the art of Sydenham, and yet there may be lacking in him those finer qualities of heart and head which count for so much in life.—Sir William Osler.

A CASE OF A PSEUDOHERMAPHRODITE WITH EXSTROPHIC BLADDER

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Recently, while the writers were connected with Sterling College, Sterling, Kansas, they had an occasion to study a seven months old fetus which represented a rare combination of anomalies of the pelvic region. We are indebted to Dr. C. A. Hellwig, Pathologist, St. Francis Hospital, Wichita, who graciously placed the specimen at our disposal for study. An unsuccessful effort was made to secure photomicrographs of the gonads and other tissues. Evidently due to improper fixing of the tissues, it was impossible to get histological sections satisfactory for photomicrography; however, the sections were clear enough for study so as to identify the general nature of the tissues.

The history of the case is unknown to the writers. The specimen was well developed and about normal in size. Dr. Hellwig, in an autopsy, had already disclosed a spina bifida of the lumbar region. Except for the genitalia no abnormalities were at first observed externally. Internally the anomalies present were in connection with the urogenital system and the large intestine.

Careful examination revealed the following unusual anomalies: The anal opening was absent, suggesting at first an imperforate anus; however, further examination revealed the fact that the rectum opened in the median line anterior to the female orifice (Fig. I, AN and UT). The anal fissue between the buttocks was normal. A section through this fissure revealed well developed sphincter muscle fibers in the region where the anus is normally located. The large intestine was well developed, being about fifty cm. in length and from four to eight mm. in diameter (Fig. II, R). Cephalic to the sigmoid, the colon had failed to assume its normal descending, transverse, and ascending position. Instead, it lay in a coil of four loops, the first bend was 1.5 cm. above the cecum. The cecum, located on the right side, was short and tapering, with a complete absence of a vermiform appendix.

Anterior to the anal fissure was a paired scrotum; the two lobes were nearly two cm. apart (Fig. I, SS). The left scrotal sac was slightly larger than the right;

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both had the cutaneous rugae well developed. Examination of the abdominal cavity showed two testes, with well formed epididymes and vasa deferentia, located slightly below the kidneys on the dorsal body wall, the right one being slightly lower than the left (Fig. II, RT and LT). They were nearly alike in size; the right one measured ten by six by five mm., while the left one measured seven by seven by five, including the epididymis. The diaphragmatic ligaments were quite evident, extending from the testes up to the diaphragm, while the gubernacula extended to the floor of the pelvis where they passed through the inguinal canals directly into the scrotal sacs.

Histological examination of the testes revealed a rather small amount of testicular tissue, although the seminiferous tubules showed characteristic fetal development. The epididymes and vasa deferentia were normal as far as could be ascertained. Seminal vesicles, prostate, and Cowper's glands were absent, as was also the urethra.

In the region midway between the two scrotal sacs and the umbilical cord (Figs. I and II, UM), which was slightly to the left of the median line, lay two large masses, the lateral lobes of an exstrophic bladder (Fig. I, LM). Between these two masses was the opening of the rectum, which was in slight prolapse due to weak development of the sphincter muscles in its wall. Caudal to the anal orifice, and partially obscured by the prolapsed rectum, was the opening leading to a well formed uterus (Fig. I, UT and Fig. II, U). About five mm. cephalad, and slightly to the right, from the opening of the intestine was a small rounded phallus, measuring six mm. in length and 2.5 mm. in diameter (Fig. I. P). This small penis terminated in a distinct glans with the frenulum prepucii on the ventral side. There was no urethral orifice present, nor was the penis flattened; however, the epithelium of the exstrophic bladder, from the right mass, reached to the base of the penial structure, suggesting the epispadiac condition so generally associated with this type of anomaly.

The exstrophic bladder was represented essentially by the two laterally located, rounded masses, which were covered with quite deep, but irregular, folds, somewhat concentric in arrangement (Fig. I, LM). In the center of the left mass was a pit, but there was no duct in connection with it. The ureteral and vasa deferential openings could not be located on any part of the exterior surface. Histological examination of these areas revealed the transitional type of bladder epithelium, covering these two lateral masses and extending cephalomesially until they nearly met in the median line anterior to the rectal opening. From the mass on the right side a ridge of this rough and red skin extended forward, connecting with the base of the small penis, where it formed a slight swelling a few millimeters in height.

The umbilicus was lower than usual, being about one cm. above the anal opening, and slightly to the left of the median line. The two umbilical arteries, of which the left one was larger than the right one, fused at the base of the umbilicus into one rather

Fig. I. Showing external anomalies of fetus. AN, anus; LM, lateral masses of exstrophic bladder; P, penis; SS, scrotal sacs; UM, umbilical cord; UR, opening of right ureter; UT, opening of uterus; UV, opening of left ureter and vas deferens; VD, opening of right vas deferens. Fig. II. Fetus with ventral body wall folded back, exposing pelvic viscera. LF, left fallopian tube, LT, left testis; R, rectum; RF, right fallopian tube; RT, right testis; U, body of uterus; UM, umbilical cord.





large vessel. Otherwise nothing abnormal was observed in the cord.

The pubic bones were far apart, failing to form a symphysis. The right vas deferens, which measured sixty mm. in length, extended through the pelvic floor, opening on the caudomesial edge of the right exstrophic bladder mass (Fig. I, VD). The opening of the right ureter was on the same swelling about one mm. caudomesiad to the opening of the vas (Fig. I, UR). The left vas deferens, which was forty-two mm. in length, united with the left ureter after having passed half way through the pelvic wall, opening on the lower median side of the left swelling (Fig. I, UV).

A uterus was located in the pelvic cavity caudodorsal to the rectum (Fig. II, U). Its passage to the outside just caudad to the anal opening (Fig. I, UT), was without any sign of vagina or constricted cervex. The folds of the uterine mucosa and submucosa extended to the exterior where they merged into the transitional epithelial folds of the exstrophic bladder. The body of the uterus measured anteroposteriorly eighteen mm., laterally at the fundus eighteen mm., and at the neck, where it was attached to the body wall, thirteen mm., and dorso-ventrally eleven mm. From its anterior surface, and in the median plane, projected a tapering process seven mm. in length, pointing caudally. The lumen of the uterus extended to the tip of this process as well as into the Fallopian tubes. These tubes, however, lacked the abdominal ostia, they being patent only to near the cranial end where the ducts rounded off smoothly to a complete closure, instead of opening in a fimbriated expansion. The left tube was much larger than the right; they measured sixty-five mm. and twenty mm. in length, and 3.5 mm. and 1.5 mm. in diameter, respectively (Fig. II, LF & RF). Ligaments were poorly developed, leaving the tubes as well as the uterus practically free in an open pelvic cavity. No ovaries or ovarian tissue could be found.

Of the urinary system, the two kidneys with their ureters were present, with an exstrophic bladder of the complete type, as described above. The left kidney was considerably larger than the right; they measured fifty-three by thirty-five by thirty-three mm. and thirty-four by twenty-one by twenty-two mm., respectively, in length, width, and thickness. Instead of being smooth and firm, they were highly vesicular and spongy, the left one with cysts up to ten mm. in diameter. Renal glomeruli and tubules were found scattered between the numerous cysts, without having formed a distinct cortex and medulla. The adrenal glands were also present. The one over the left kidney measured twenty-seven by twenty by three mm., while the one on the right side was much smaller. A section of the left gland revealed a hypertrophy of the cortex.

A search of the literature available to us has failed to reveal any case of hermaphroditism in connection with exstrophic bladder. Some form of genital anomalies, such as cryptorchidism, epispadias, atrophic or complete absence of prostate and seminal vesicles in the male, and epispadias and other anomalies in the female, seem to be invariably coexistent with exstrophic bladder (Young[5], 1926). Also such other anomalies as polycystic kidneys and spina bifida are usually present. The case herein described, however, is a pseudohermaphrodite, having a well developed uterus with Muellerian tubes besides the cryptorchid condition of the male, with the usual anomalies associated with exstrophic bladder.

von Geldern[3] (1924) describes an interesting case of exstrophic bladder which is very similar to the case herein described, except that ours lacked the two large diverticula he describes in his case. Wood-Jones[4] (1912) says that the trilobed structure of the bladder is so very characteristic of all types of exstrophy. Our specimen, however, had only a bilobed bladder, unless the slight swelling at the base of the small phallus with its connecting ridge would represent the third lobe.

We shall not go into the formation of such anomalies, as other writers recently have reviewed the different theories of their etiology; von Geldren reviewed the theories of the etiology of exstrophic bladder, and Kwartin and Hyams[1] (1927) reviewed the literature on hermaphroditism. Since that time a number of other cases have been added to the literature—in none, however, a combination of hermaphroditism and exstrophic bladder. Recently McCahey[2] (1938, 1939) has discussed the significance of sex in relation to hermaphroditism and the etiology of such anomaly. According to his classification our specimen would come in the category of group four, a genetic female described as a male pseudohermaphrodite with Muellerian derivatives.

SUMMARY

An unusual case of exstrophic bladder in a seven month fetus is described as coexistent with spina bifida, polycystic bladder, epispadias, intestine opening on exstrophic area, absence of prostate and seminal vesicles, and a cryptorchid male pseudohermaphrodite with well developed uterus and fallopian tubes.

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THE RICKETTSIAS AND THE PATHOGENIC VIRUSES —OUR PRESENT ORIENTATION

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Wars of major scope or widespread famines have been accompanied or immediately succeeded by outbreaks of contagion of unusual types, to which immunity has not been obtained.

During the Civil War typhoid and dysentery caused the deaths of many more than fell in battle. During World War I a pandemic of influenza of a type never before encountered swept the entire world presenting unusual clinical manifestations and pulmonic complications resulting in an unusually high mortality. It affected largely those of military age of both sexes, sparing the young and the aged. Its lethal character and the rapidity with which it ran its course, frequently terminating in death, was disconcerting to the medical profession as it was found resistant to known forms of therapy.

Governments have in recent years carried on extensive immunization with the result that morbidities from the more common types of infection have been reduced to a negligible number.

Recent newspaper reports indicating a serious outbreak of typhus fever among German and Italian troops leads us to consider this morbidity, due to the fact that this disease is usually prevalent under war time conditions or those of want or famine and is of special interest as our own troops may become the victims of this formidable malady, the etiology of which is still a matter of controversy. Since it is classed as belonging to the Rickettsias, which in turn are allied to the pathogenic viruses, a review of these and their relationship to our more common morbidities seems justifiable. The condition known as typhus exanthematique has been recognized in medical literature under various titles such as pestilential fever, spotted fever, camp fever, jail fever, ship fever, etc., since the sixteenth century.

The predisposing causes are of course the mobilization of large groups of men producing severe conditions of over-crowding, states of famine, etc. The immediate transmitting agent is the body louse, which appears to be the principal vector. A severe epidemic occurred in Serbia in 1915, and a similar outbreak occurred in Bulgaria in 1916. It is estimated that since World War I over a million people have died of this disease in Europe. The association of this disease with a parasitic vector was noted in the seventeenth century by Cober, but it was only in 1909 that Nickolle, Compte and Conseil absolutely proved the transmissibility of this disease by pediculi. In the United States in 1892, eight of twelve physicians in Bellevue Hospital who contracted the disease died. The history of the tremendous amount of research that has been undertaken is too voluminous to be quoted, except to briefly review these Rickettsias as related to our present orientation of the pathogenic viruses about which we know less than we do about other types of infective disorders.

The fact that the present theater of war is largely in the tropics, and that the types of disease to which mobilized troops may be exposed belongs largely in the category of tropical medicine, of which we in temperate climates know little, prompts a consideration of some that may perhaps prove of interest in relation to the outbreak of diseases among mobilized troops with which we are entirely unfamiliar.

The Rickettsias are diseases due to a group of bacteria-like organisms transmitted through parasitic vectors. Some are highly pathogenic, others relatively innocuous. This group has been submitted to intensive study by a number of research workers, including Ricketts, an American pathologist, who with many others have fallen martyr to the disease that bears his name. They found that these bodies that had never been clearly determined as bacteria were found largely in the intestinal tracts of lice and ticks, many of them definitely associated with specific forms of disease, as for instance, the R. conori, recognized as the cause of Mediterranean exanthematous fever, the R. nipponica, regarded as the cause of the Japanese disease Tsutsugarmushi, the R. prowazeki, an organism found in the digestive tract and in the epithelial cells of the lining of the intestinal tract of lice who have bitten typhus fever patients, the R. psittaca, found in the tissues of parrots with psittacosis, and the R. quintana, found extracellularly in the intestines of lice that have bitten trench fever patients and regarded as the probable cause of this disease.

Like many of the virus diseases the Rickettsias are characterized by inclusion bodies, and it has not been clearly demonstrated whether the virulent factor may be attributed to the specific bacteria-like organisms

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or to virus transmission, the organisms being merely a side issue, similar to the Negri bodies in rabies.

The filtrable viruses have long been recognized as disease producing entities but our conception of the morphology they represent has undergone a radical reconstruction as science has gradually unveiled many of the perplexing questions that clouded a clear understanding of their nature in earlier writings, although it brings us to a consideration of certain as yet only partially understood phenomena.

More recent researches in the scientific field have developed sufficient data to make a general review of the subject interesting. In the beginning studies of virus diseases it was believed that these were the result of ultramicroscopic protozoa or bacteria. A study of the physical symptoms and of tissue and blood changes was carefully carried out. Earlier writings offered as clinical guides the fact that certain viruses exhibited a peculiar predilection for attacking nervous tissues, while in others the ectodermal structures were those involved. We were particularly interested in the neurotrophic types of viruses because of their association with poliomyelitis. We were less impressed with their significance as relating to the more common diseases regarded as contagions and prevalent among our younger group with physical signs that were supposed to be characterized by three outstanding clinical features, namely, a biphasic temperature curve, leucopenia and inclusion bodies. More recent investigations have placed less value on the presence of inclusion bodies than that of former writers as it is believed that these inclusion bodies are found only in about fifty per cent of the types of diseases attributed to virus infection. Again with reference to the morphology of these bodies we find a marked variation. Those found in herpes, chickenpox, and yellow fever are apparently morphologically identical while the Guarnieri bodies of smallpox and the Negri bodies of rabies exhibit an entirely different morphology.

The gradual identification of a group of diseases traceable to a filtrable virus or to invisible filter passing pathogenic agents began with Pasteur's study of rabies. He was the first to suggest the possibility of invisible micro-organisms. To Iwanowski, whose studies in 1893 in relation to the Mosaic diseases of tobacco demonstrated this was caused by a filtrable virus, much of the development of later study of filtrable virus is due. In 1898 both Loeffler and Frosch recognized this agency in the causation of foot and mouth disease and since that time research has patiently mobilized a mass of factual data that attests the brilliant achievement of research workers. Most of the contributions relating to research in the field of virus diseases have appeared in the less widely read journals such as the Journal of Experimental Physiology, Experimental Medicine, and Experimental Biology. So far as I can learn, the first attempt to place before the medical profession a concise and lucid presentation of virus diseases was by Pepper in 1932. (1) At that time he listed fifteen diseases in man as due to this agency while a hundred diseases affecting the animal and vegetable kingdom and even insects were determined as resulting from a virus. The fact that the common diseases with which the clinician most frequently deals are in many instances the result of virus infection makes this subject one of general interest. Many of the diseases at first classified as belonging to this group have more recently been found to have a bacterial origin, while on the other hand a considerable number of obscure etiology have been conclusively proven as belonging in the virus category. Goodpasture and Rivers, working independently, have thrown much light on the nature of virus disease. Rivers (2) lists the following as due to this agency: Measles, German measles, mumps, herpes, rabies, herpes zoster, varicella, vaccinia, poliomyelitis, lymphogranuloma inguinale, foot and mouth disease, Australian X disease, louping ill, Reft valley fever, yellow fever, pappataci fever, dengue, warts, molluscum contagiosium. To these may be added Economo's disease and certain of the Rickettsias to which group it is presumed typhus fever and Rocky Mountain spotted fever belong. Modes of transmission are at present recognized as by insect vectors, by contagion (human or animal), by tissue abrasion, and by other methods as yet undetermined. Of the viruses transmitted by insect vectors, yellow fever, dengue, and pappataci fever are examples, though their infrequent occurrence in temperate climates makes them less interesting than those that are more commonly encountered, which comprise some of our most frequent types of morbidity.

While there seems to be a greater susceptibility to virus infections in childhood and early life, no age is exempt. The commoner mild types such as mumps, measles, epidemic colds, smallpox and chickenpox, may occur at any age though they are infrequent after the mid-period in life. Diseases due to neurotrophic viruses are infrequent after middle life except those transmitted by tissue abrasions, such as rabies.

The incubation of the various groups varies widely. They usually require two weeks or longer to incubate but in certain of the milder types such

(Continued on Page 194)

President's Page

To the Members of the Kansas Medical Society:

As your President, I have had my first opportunity of attending a house of Delegates meeting of the American Medical Assotion.

After being there, I have the very definite feeling that the Delegates as a whole are very high class physicians, that they are endeavouring to render to our profession a service that is extremely difficult, especially during these times.

Due consideration was given to each resolution before the various reference committees and, so far as I could determine, the final decision in each case was the wise procedure.

Unless one understands all the various angles of a problem he is apt to be critical of decisions made. So often we hear some individual offer criticism of a physician for making a certain diagnosis or prescribing a certain drug, yet, if we knew the physical findings that were present at the original examination, we likely would have made the same diagnosis.

If your President makes mistakes this year, and no doubt I will make many, will you please be tolerant and consider the many angles to the problem involved.

Sincerely,

J. L. Lattimore M.D.

President, The Kansas Medical Society

EDITORIAL

Members who have not filled out and sent in their classification cards are most urgently requested to do so at once. It is imperative that this information be on file for reference and information immediately.

FORREST L. LOVELAND, M.D.,
Kansas Chairman of Procurement
and Assignment.

A.M.A. CALLS EDITORS AND BUSINESS MANAGERS MEETING

At the instigation of the officers of the American Medical Association a meeting of all editors and business managers of medical journals was called in Chicago on June 5, to allay the spirit of discontent which had been seething in some few of the journal offices for the past few years.

Dr. Olin West, director and committee member for the Cooperative Medical Advertising Bureau, conducted the meeting, which he said was called not in the spirit of destructive but of constructive criticism. Several letters had been mailed to some of the state journal editors criticising the bureau in many ways. Parts of these letters were read and the questions answered by Dr. West and Mr. Braun, another committee member.

Dr. West opened the meeting by giving a brief history of the Cooperative Medical Advertising Bureau, which was organized in 1914 at the request of the state journals which at a great deal of labor and expense were able to secure only a small bit of inferior advertising for their state medical publications. The Council on Pharmacy and Chemistry was then organized in order that approved products would be acceptable for advertising in the journals. The council has made such a great impression on the manufacturers that the standards of products have been greatly improved and the persistent campaign supported by such a large group of meritorious medical publications has brought a beneficial change in both foods and drugs in this country. Government agencies frequently depend on the word of the council for guidance in this field and the food and drug standards of the nation in general have been greatly benefited. Although manufacturers must submit their products for examination before approval is given, some products are not submitted due to the fact that the manufacturer knows that they do not come up to the specified standards.

At the present time there are thirty-five medical journals recognized by C.M.A.B. It had been suggested that the Journal of the American Medical Association got the bulk of the advertising and the state journals got only what was left. Dr. West said that this was not true but that the A.M.A. was a separate unit. The question was asked as to ratio of circulation of the Journal of the A.M.A. to that of the state journals. Although this was not figured out at the meeting, the Journal of the A.M.A. has a circulation of 100,000 which compares to the smallest journal circulation of 300; however, the ratio of state members receiving state journals as compared to state members receiving the Journal of the A.M.A. varies in many states, with some states falling low in the total number of A.M.A. Journals received. We believe there would be no justification in working out that type of ratio for a one state campaign and that, therefore, when advertising is used in both the state and national journal it has a double-barreled effect. The faith of many a member in his state publication is so grounded that seeing the same advertisement in the national publication accentuates the good work the state publication has already started.

The possibility of divorcing the state journals from the Cooperative Medical Advertising Bureau was discussed. The Kansas Journal believes that the ones who advocate this plan, especially at this time, cannot know the difficulty of securing and promoting such a program. For an initial program of this type there would need to be six months at the least of preparation, with money advanced in the amount of several hundreds of dollars by each journal, to assure the cost of setting up an office, travel, stationery, supplies, advertising, sales force, not to include the small items of bookkeeping, addressing, mailing, filing, and informational data that goes into building up a campaign for this sort of advertising program. Severing connections with the A.M.A. would mean also severing connections with the Council, the contact with approved products and the advertising that is secured therefrom, as well as a great loss of prestige. Medical journals are not run for profit,—at least the Kansas Journal is not—but to disseminate good useful material and information to its readers, and advertise the products which have proven qualities and known values.

Although the main discussion was advertising for the journals, a request was made that the state journals have more representation on the Cooperative Medical Advertising Bureau Committee, which is composed of: Dr. Olin West, Mr. Will Braun and Dr. Walter E. Vest, from Virginia, the only representatives of the state journals. Dr. West agreed

to take the matter up with the Council and present the request that from three to five or seven physician-journal representatives from the various states be added to the committee. It was requested that the committee meet regularly, the committee meet more often, and that reports of such meetings be made.

Dr. West presented a complete financial report for advertising in the amount of $213,799.12 for the year ending November 30, 1942, showing the income and expense of the bureau. The cost of operating the bureau for that period was $14,750.55 which included salaries, department-service, postage, telegraph and telephone, freight and express, printing, travel, rent, commissions, advertising in the Directory of the A.M.A. for each state journal, and office supplies. According to the income and expense report the bureau operates on approximately 6.89 per cent, which is a very low figure compared to the cost of securing advertising from an agency where commissions are from 15 to 25 or more per cent.

The meeting was a very enlightening one and probably has resulted in creating a much better co-operative spirit between the journal representatives, the A.M.A. and the bureau. Dr. West extended a hearty invitation that all editors and business managers come to the American Medical Association building and see for themselves just how the different departments work.

KANSAS MATERNAL AND INFANT CARE PLAN FOR SERVICE MEN'S DEPENDENTS

The Kansas State Board of Health, the Kansas State Hospital Association and the Kansas Medical Society have jointly cooperated in the new maternal and infant care plan for service men's dependents, which it is hoped will be in full swing in the state in a very short time, according to the information received from the office of Dr. Fred Mayes, Director of the Division of Maternal and Child Health of the State Board of Health.

In discussing the plan, Dr. Mayes had the following to say: "The new plan for maternal and infant care for service men's dependents is, according to high ranking army officials, one of the biggest morale builders for service men that the government has yet inaugurated."

Soon after Congress passed the act on March 18, 1943, appropriating $1,200,000 for the civilian medical and hospital care of wives and infants of men in service in the various states and territories, the Kansas State Board of Health, the Society Committee on Maternal and Child Welfare, and representatives of the Kansas Hospital Association, took steps to secure the Federal grants for Kansas.

It was necessary to get the plan in action as soon as possible, since fifteen per cent of the present Kansas births are children of men in service, and many of the mothers are unable to secure adequate prenatal, delivery, postnatal and pediatric care for themselves and the babies, because of limited government allotments.

The Kansas plan is similar to plans now in active operation in the following states and territories: Arizona, Arkansas, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Michigan, Mississippi, Missouri, Nevada, New Jersey, North Carolina, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.

The inspection of all hospitals not approved by the American College of Surgeons, that plan to participate, is required by the act. Inspection of the Kansas hospitals has been under the supervision of the Board of Health or county health officer, assisted by the doctors, and a member of the Kansas State Hospital Association.

Physicians participating in the plan must be graduates of a class "A" medical school or approved by the state health officers technical advisory committee. The act makes this very specific and reads as follows: "Medical care provided under the plan will be authorized only when the attending physician or consultant is a graduate of a medical school approved (at the time of graduation or subsequent to graduation) by the Council of Medical Education and Hospitals of the American Medical Association. For the period of this emergency program individual exceptions may be made when a person with the degree of Doctor of Medicine who is not a graduate of a medical school approved (at the time of graduation or subsequent to graduation) by the Council of Medical Education and Hospitals of the American Medical Association has completed postgraduate training in obstetrics and/or pediatrics which, in the opinion of the state health officer and his technical advisory committee, makes him competent to participate in this program."

It was necessary for Dr. Mayes and his staff to complete a great deal of work before the program could be announced. After the plan had been approved and the Federal Funds allocated to the State Board of Health (none of the funds can be spent in promotion or administration but only in the actual work itself), forms had to be prepared for all records. There are individual forms for the doctor to fill out, made as simple as possible to conserve time and effort, forms for the hospital, the mother and forms for records of the infant. The doctor's and

hospital reports are the basis for the bill. The care of the infant under this plan is only during the first year of life. Information on the plan and forms may be secured by writing to the Division of Maternal and Child Health of the Kansas State Board of Health.

THE RICKETTSIAS AND THE PATHOGENIC VIRUSES—OUR PRESENT ORIENTATION

(Continued from Page 190)

as colds and vaccinia the incubation period is short and noticeably shorter incubation by insect vectors is noted. The incubation period of rabies is of course definitely influenced by the site of abrasion, while the period of incubation required for other types is difficult to determine not only because of variations in virulence and individual resistance but because the exact time of exposure cannot be determined. As in other diseases of infective type, many persons are immune who may become constant carriers. The exhibition of tissue predilection, particularly of the neurotrophic types, presents many interesting angles for study. Acquired immunity is assumed to be conferred in about fifty per cent of cases although the milder forms of infection such as colds confer no, or only temporary, immunity.

Contemporary research seems to have completely disproven our older concept that the pathogenicity of the viruses is due to any form of living organism. They are now regarded as specific morbid agents entirely unrelated to living organisms, probably a protein incapable of growth or multiplication except in the presence of living cells, but capable of disturbing symbiotic relationships in the same manner as bacterial toxins.

Plotz reports the cultivation of a small nonmotile anaerobic gram positive bacillus found in connection with typhus in some cases. Numerous other investigators have found a bacillus of similar morphology associated with Brill's disease presenting difficult cultural conditions and with rapid disappearances of virulence under cultural methods. Inasmuch as other investigators have reported the infection as carried by a filtrable virus, the assumption is strengthened that this disease is definitely of virus origin, inasmuch as it is stated the bacillus of Plotz is not filter passing. This fact leaves the pathogenic excitant in doubt but rather strengthens the concept of its virus transmission.

Dr. Abraham Newirth of the United States Army using the technic of Cox has attempted immunization against typhus but results up to the present time have been only partially successful.

COMMENT

We have not properly evaluated the role of the pathogenic viruses in our general concept of disease processes. The probability that these will assume a position of great importance in the morbidities of our combat group in the present theatres of action as well as a realization of their importance in relation to many prevalent disorders on the home front would appear to justify the above review.

The assumption seems justified that as bacteriologic research will continue to reveal methods of dealing adequately with diseases of bacterial origin, we have still the mystery of virus diseases and should direct our efforts to the development of methods of dealing with these more obscure conditions concerning which we know so little but which will inevitably demand solution. It is gratifying to note that much has already been accomplished by our American research workers in this field. It may be confidently predicted that history will repeat itself and that following this the greatest conflict of all time, with famine or near famine facing the conquered countries of Europe, we will have a pandemic of world-wide proportions, not of infectious nature, against which immunization may be effective, but probably of virus origin.

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NEWS NOTES

A.M.A. MEETING

The annual meeting of the House of Delegates of the American Medical Association was held in Chicago on June 7-10, 1943. Those who attended from Kansas were: Dr. J. L. Lattimore, president of the Society, of Topeka; Dr. Forrest L. Loveland of Topeka and Dr. J. F. Hassig of Kansas City, delegates from Kansas; and Mr. Robert Brooks of Topeka, the executive secretary.

One hundred and fifty-five elected delegates and twenty sectional delegates attended with every state society represented.

The following new officers were installed for the year: Dr. James E. Paullin of Atlanta, Georgia, as President; Dr. Herman L. Kretschmer of Chicago, Illinois, as President-Elect; Dr. J. W. Amesse of Denver, Colorado, as Vice-President (the only real contest at the meeting); Dr. Olin West of Chicago was re-elected as Secretary and General Manager; Dr. H. H. Shoulders of Nashville, Tennessee, as Speaker of the House of Delegates; Dr. R. W. Fouts of Omaha, Nebraska, as Vice-Speaker of the House of Delegates; Dr. Ernest E. Irons of Chicago and Dr. William F. Braasch of Rochester, Minnesota, were re-elected to the Board of Trustees.

ANNUAL RE-REGISTRATION

The annual registration fee for Kansas doctors of medicine is due on July 1, 1943. Until October 1, 1943, the fee is $1.00 after that date, however, the law fixes the penalty of $5.00, the amount required for reinstatement of a license.

The 1943 Kansas legislature passed a law releasing physicians in the armed service from the payment of the annual fee, during their term of service. Until the new law was enacted payment for the fee could not be waived for any reason whotsoever.

Dr. J. F. Hassig, secretary of the Kansas State Board of Medical Registration and Examination is sending notices to all physicians, however, if you do not receive your notice due to a change in address or for some other reason the address of the board is 905 North Seventh Street, Kansas City, Kansas, and fee should be mailed to them direct.

NARCOTIC PERMITS

Federal narcotic permits must be renewed by June 30. Renewal of narcotic permits must be made through application to the office of Collector of Internal Revenue at Wichita. The attention of the membership is called to this renewal of narcotic permit in order that they may avoid the payment of a penalty.

WINTER GENERAL HOSPITAL

The dedication services of the Winter General Hospital were held in Topeka on May 22 before a large audience. The membership of the Kansas Medical Society is happy to welcome its competent medical personnel to the state. Speakers on the dedicatory service program were: Governor Andrew Schoeppel; Major General Frederick E. Uhl, Commanding General of the Seventh Service Command; Lieutenant Colonel Waldo B. Farnum, Chief of the Medical Service of Winter General Hospital, whose eulogy to General Winter is published in this issue of the Journal; and Major Samuel T. Whitebread, Area Engineer of the United States Corps of Engineers, who formally delivered the hospital to the Medical Department.

The one-story plan of the hospital, units being joined by enclosed runways, is similar to that used in the building of the O'Reilly General Hospital at Springfield, Missouri, and is the plan used in many of the general hospitals being built today, with a few exceptions of the two-story under one roof type. Winter General Hospital, one of the forty-three named general hospitals, has a 1,777 bed capacity, for all types of patients. No direct information as to the possibility of increasing the bed capacity has been planned but the design is such that additions may be made to the hospital at any time. Two changes have been made in the original design by the addition of a Medical Clinics building and Receiving and Disposition building as separate units. It is hard to realize the great size of the hospital from pictures or a front view, but a birds-eye view gives an accurate idea of the hospital as a unit. (The air-photograph was published by special permission and was taken by the United States Army Air Force.)

The hospital has three types of wards — the standard wards having thirty-three beds; the combination wards with ten private rooms and sixteen ward beds; and four closed wards for mental patients.

The hospital is complete in every detail, the finest medical, dental, laboratory, orthopedic, E.E.N.T., operating room, and x-ray equipment both portable and stationary, that is to be found in the world today is in every needed place in the hospital. The wards have the best of equipment for the care of the wounded and sick and facilities are available for every comfort. In the five kitchens, the stoves, fryers, and food-storage rooms, as well as the materials for preparing the meals and the special diets, are the best that our government can secure. The dining-rooms function cafeteria style, with everything arranged for the greatest efficiency and the best possible service. There are two enlisted-patient, one detachment and two officer-patient dining or mess halls.

There is a beautiful chapel, an adequate auditorium in the Red Cross building, a branch post office in connection with the Topeka post office, and automatic fire alarm and sprinkler equipment in each building in addition to the usual manual fire control system.

Three hundred civilian employees are now working at the hospital and this number may be increased as the need arises. If for therapeutic reasons it is decided that a convalescent patient will be aided in his recovery by being assigned to some certain duties, this may be done. At the present time there are 45 nurses, 30 medical corps officers, 15 medical administrative corps officers, 5 dental corps officers, 2 quartermaster officers, 2 engineer corps officers, 2 chaplains, 2 sanitary corps officers, 1 post exchange officer, 1 physio-therapy aide, 1 dietitian, 1 finance officer and approximately 700 medical detachment men and 40 quartermaster detachment men (soldiers) on duty at the hospital.

Colonel John W. Sherwood, Medical Corps, is the Commanding Officer of the hospital. He was born in Maryland in 1881, graduated from George Washington University Medical School in 1908, appointed in the Army in 1909, served in the World War as a Major and as a Lieutenant Colonel and received his promotion to Colonel in 1938. He came to Winter General Hospital from duty as Department Surgeon in Panama, where he had served previously in 1928-1931. He also was in the Philippine Islands from 1915 to 1917. He served in Walter Reed General Hospital, Washington, D. C.; Fort Sam Houston, San Antonio, Texas; in Panama at Gorgas Hospital; Fitzsimons General Hospital, Denver, Colorado; and station hospitals at Fort Snelling, Minnesota, and Fort Slocum, New York.

Lieutenant Colonel Milford T. Kubin, Medical Corps, a former Kansas Society member who lived in McPherson, is now Executive Officer at the hospital. Colonel Kubin was temporarily in command of the hospital prior to Colonel Sherwood's arrival. Lieutenant Colonel Waldo B. Farnum, Medical Corps, is Chief of the Medical Service at the hospital and his former home was in New York City. Lieutenant Colonel Daniel L. Yancey, who formerly lived in Springfield, Missouri, is the Chief of the Surgical Service. Major Hugh G. Grady, Drexel Hill, Pennsylvania, is Chief of the Laboratory Service; Major Raphael Pomeranz, Newark, New Jersey, Chief of the X-ray Service; and Major Galen A. Rogers, Talihina, Oklahoma, Station Surgeon.

The following medical officers are assigned to the Medical Service: Major Forrest Anderson, Van Nuys, California; Major Sam Phillips, Little Rock, Arkansas; Major George Robson, San Francisco, California; Major Nathaniel Uhr, New York City; Captain Max Berkovsky, New York City; Captain Henry Gahan, Winchester, Massachusetts; Captain Max Magnes, Sea Gate, New York; Captain Meyer G. Miller, Wilmington, Vermont; Captain Millard

T. Peterson, Atlantic, Iowa; Captain Isadore Schapiro, Brooklyn, New York; Captain George Skura, Brooklyn, New York; First Lieutenant Thomas F. Ahearn, Chicago, Illinois.

The following officers are assigned to the Surgical Service: Major Charles Alexander, Houston, Texas; Major Sidney Bernstein, Brooklyn, New York; Major Ralph B. Mullenix, San Diego, California; Major Matthew Peelen, Kalamazee, Michigan; Major Walter A. Reese, Middletown, Ohio; Captain Orrin Anderson, Clifton Springs, New York; Captain William Ellett, Appleton City, Missouri; Captain Henry Mosher, Dayton, Ohio; Captain Conrad I. Karleen, Tracy, Minnesota; Captain Joseph Lovering, New York City.

Lieutenant Colonel Henry Sydenham, Dental Corps, Coleman, Texas, is Chief of the Dental Service. The following dental corps officers are members of his staff: Major Clair J. Wilson, Hays, Kansas; Captain Robert E. Brown, West View, Pennsylvania; First Lieutenant Edwin H. Getz, Forest Hills, L. I., New York; First Lieutenant Arthur H. Walden, Colorado Springs, Colorado.

AVIATION MEDICAL EXAMINERS

The Journal of the American Medical Association for May 29, published a list of aviation medical examiners who graduated on March 11, at the School of Aviation Medicine in Texas and the three army air forces classification centers. The Kansas students who graduated were as follows: Spencer H. Boyd, First Lieutenant of Topeka; Samual T. Caughlin, Major of Larned; James G. Gaume, First Lieutenant of Ellinwood; and Edwin R. Hill, Jr., Major of Lyons.

OUTLINE OF PLAN

For Emergency Maternity and Infant Care of Dependents of Service Men.

I. General Information:
 1. Program provided by Act of Congress, March 18, 1943.
 2. Funds available from U. S. Children's Bureau, through State Health Departent, Division of Maternal and Child Health.
 3. Kansas plan prepared by representatives of Kansas Medical Society, Kansas Health Department, and Kansas Hospital Association.
 4. The plan is to be in action only during the period of the present war emergency.
 5. None of the money in this appropriation can be spent for administration—every dollar must be paid for medical or hospital services.
 6. Application for care to be made jointly by the pregnant service man's wife and her family physician, and sent to the Division of Maternal and Child Health, State Health Department, Topeka.
 7. Provision of medical and hospital care under this plan will not be retroactive to include care or service already rendered, but will begin at the visit when the request for authorization is signed by the physician.
 8. Participation in this program is voluntary. No expectant mother, sick infant, physician, nurse or hospital is required by law to participate.

II. Those Eligible for Care:
 1. Any pregnant woman in Kansas without regard to financial status, or length of residence in Kansas, whose husband is a "buck" private, first class private, corporal, or sergeant (or equivalent grades) in the U. S. armed forces.
 2. Any premature or sick infant in Kansas, under one year of age, whose father (in the above mentioned grades) is serving in the armed forces.

III. How to Apply for Care:
 1. Application forms will be made available through local physicians, hospitals, public health authorities, welfare organizations, Red Cross chapters, and military establishments.
 2. The prospective mother and her family physician complete the application form, including her husband's serial number.
 3. Completed application form is mailed to the Director, Division of Material and Child Health, State Health Department, Topeka.
 4. Authorization for care is granted immediately, provided the expectant mother (or sick infant), the attending physician, and the hospital designated are all eligible to participate in the program.
 5. The State Director of Maternal and Child Health promptly notifies the patient, the physician, the hospital, and the local full-time public health officer or nurse, whether or not the care is authorized.

IV. Services Provided for the Patient:
 1. Complete medical care for maternity patients during the prenatal period, delivery, and six weeks thereafter — including care of complications, operations, postpartum examination — and for the newborn infant.
 2. Medical care of premature of sick infants, under one year of age.
 3. Hospital care in wards or at ward rates for maternity patients (including their newborn infants), and premature or sick infant under one year of age.
 4. Public health nursing instruction and supervision, in districts where such is available; and emergency bedside nursing care for acutely ill maternity patients or sick infants.

V. Physicians Eligible for Participation:
 1. Attending Physician
 a. Graduates of medical schools approved (at time of graduation or subsequent to graduation) by the Council of Medical Education and Hospitals of the American Medical Association, and licensed to practice medicine and surgery in Kansas.
 b. Those, in lieu of the above qualifications; who are licensed by the Kansas Board of Medical Registration and Examination, and who have completed postgraduate training in obstetrics and/or pediatrics which, in the opinion of the State health officer and his technical advisory committee, makes him competent to participate in the program.
 2. Consulants (Obstetrics or Pediatric):
 In addition to qualifying as attending physicians, specialists serving as consultants must either be certified by the American Board of Obstetrics and Gynecology, or Pediatrics (as the case may require).
 "Assistant Consultants" must qualify as attending

physicians, and must in addition have had at least one year of approved hospital training and one year of practice in the straight specialty of obstetrics or pediatrics (as the case may require), and may serve as a consultant when no certified specialist is available.

VI. Hospitals Eligible for Participation:
1. Hospitals approved by the American College of Surgeons, or
2. Those, which, after inspection, have been approved by the State Health Department as meeting the requirements outlined by the U. S. Children's Bureau in "Minimal Requirements for Approval of Hospitals and Maternity Homes for Obstetric Care Under the Emergency Program."

VII. Nurses Eligible for Participation: Those who are registered or are eligible for registration in Kansas and have had satisfactory experience in maternity and pediatric nursing.

VIII. Maximum Length of Care to be Authorized:
1. Maternity Care. Medical care from as early in pregnancy as possible, to at least six weeks after delivery. Hospital care for fourteen days. Bedside nursing care for emergencies only.
2. Sick Infant Care: Medical care for three weeks. Hospital care for fourteen days. Bedside nursing care in emergencies only.
3. Extension of care may be authorized when justified, after review of case record.

IX. Rates to be Paid to Hospitals, Physicians, and Nurses:
1. Hospital Charges: Per diem ward rate not to exceed 4.50, for maternity cases (including newborn infant), or for premature or sick infant cases (under 1 year of age). Maternity hospitalization for ten days postpartum recommended whenever possible.
2. Fees for Medical Services
 a. Maternity Care
 (1) Complete Maternity Care.....$35.00
 Includes at least five prenatal examinations, routine blood tests for syphilis, hemoglobin determinations, urinalysis, care of complications and obstetric operations, delivery, postpartum care, and postpartum examination approximately six weeks after delivery.
 (2) Delivery and Postpartum Care.....$25.00
 Same as (1), above, except that prenatal care is omitted. (For cases reporting to physician, at time of delivery or whose prenatal care has been provided elsewhere)
 (3) Prenatal Care Only.....$10.00
 As outlined above, in (1). (For cases leaving the community before delivery).
 b. Sick Infant Care (under 1 year)
 (1) First visit
 Home call$ 4.00
 Office or hospital visit.....$ 2.00
 (2) Additional visits
 Home calls$ 2.00
 Office or hospital visits.....$ 1.00
 (3) Maximum Payment
 For first week of illness.....$10.00
 For any subsequent week.....$ 5.00
 c. Consultant Services (Obstetric or Pediatric)
 (1) Consultation service$10.00
 (2) Additional distance (mileage) allowance is paid according to the following zone schedule (number of miles indicates distance from physician's home to location of patient):

Zone				
I Up to 10 mi.	II 10 to 25 mi.	III 25 to 50 mi	IV 50 to 100 mi.	V Over 100 mi.
Amount				
None	$10	$15	$25	$35

3. Emergency Bedside Nursing Fee
Prevailing minimum local rate.

For further information, or for a complete detailed copy of this Kansas plan for Emergency Maternal and Infant Care, write to the Director, Division of Maternal and Child Health, Kansas State Health Department, Topeka.

WHOSE DEPENDENTS ARE ELIGIBLE UNDER THIS PLAN—RANKS OR RATINGS OF ENLISTED MEN

(As of April 23, 1943)

ARMY—Private; Private, first class; Corporal; Technician, 5th grade; Technician, 4th grade; Sergeant.

NAVY—Aerographer's mate, third class; Aviation electrician's mate, third class; Aviation machinist's mate, third class; Aviation metalsmith, third class; Aviation ordnanceman, third class; Aviation radioman, third class; Baker, third class; Boatswain's mate (cox); Bugler, first class; Bugler, second class; Carpenter's mate, third class; Cook, third class; Electrician's mate, third class; Fire controlman, third class; Fireman, first class; Fireman, second class; Fireman, third class; Gunner's mate, third class; Hospital apprentice, first class; Hospital apprentice, second class; Musician, second class; Painter, third class; Parachute rigger, third class; Pharmacist's mate, third class; Photographer's mate, third class; Printer, third class; Quartermaster, third class; Radarman, third class; Radioman, third class; Radio technician, third class; Seaman, first class; Seaman, second class; Seaman apprentice; Ship's cook, third class; Shipfitter, third class; Signalman, third class; Soundman, third class; Specialist, third class; Steward, third class; Steward's mate, first class; Steward's mate, second class; Steward's mate, third class; Storekeeper, third class; Telegrapher, third class; Torpedoman's mate, third class; Yeoman, third class.

MARINE CORPS—Private; Private, first class; Corporal; Assistant cook; Field cook; Cook, third class; Chief cook; Field music; Field music, first class; Field music corporal; Field music sergeant; Steward's assistant, first class; Steward's assistant, second class; Steward's assistant, third class; Steward, third class; Mess sergeant; Sergeant.

COAST GUARD — Aviation machinist's mate, third class; Aviation metalsmith, third class; Bugler, first class; Carpenter's mate, third class; Coxswain; Electrician's mate, third class; Fireman, first class; Fireman, second class; Fireman, third class; Gunner's mate, third class; Mess attendant, first class; Mess attendant, second class; Mess attendant, third class; Musician, second class; Officer's steward, third class; Parachute rigger, third class; Pharmacist's mate, third class; Photographer's mate, third class; Printer, third class; Quartermaster, third class; Radarman, third class; Radio technician, third class; Radioman, third class; Seaman, first class; Seaman, second class; Seaman apprentice; Signalman, third class; Ship's cook, third class; Soundman, third class; Specialist, third class; Storekeeper, third class; Yeoman, third class.

NEW QUARTERLY REVIEW OF OBSTETRICS AND GYNECOLOGY

Volume I. Number 1 of the Quarterly Review of Obstetrics and Gynecology dated April, 1943, has come to the Editorial desk. Bound in blue, the first quarterly contains 176 pages and abstracts of 263 articles.

The quarterly is an abstract journal for obstetrics and gynecology, calling attention, according to the editor, Nicholson J. Eastman, to a vast array of articles which would otherwise be missed. It is a valuable time saver to the readers, the papers being well selected and comprehensively abstracted and the bound volumes would constitute a most useful reference work in which recent literature could be reviewed in sequence. The quarterly review will cover an increasingly large number of articles and up-to-the-minute survey of the entire world's literature in this field.

Volume I. Number 1, covers the following general subjects: Abortion, infants, labor, lactation, maternal welfare, pelvis, placenta, pregnancy, puerperium, cancer, endocrinology, infarctions, ovary, menstruation and menopause, sterility, uterus, and miscellaneous related subjects.

The editorial board for the review is as follows: Fred L. Adair, Alfred C. Beck, L. A. Calkins, Baynard Carter, Willard R. Cooke, Walter T. Dannreuther, Nicholson J. Eastman, L. A. Emge, Bernard J. Hanley, C. B. Ingraham, Frederick C. Irving, Howard F. Kane, James R. McCord, Norman F. Miller, Robert D. Mussey, Emil Novak, Franklin L. Payne, Louis E. Phaneuf, E. D. Plass, Lewis C. Scheffey, Edward A. Schumann, H. J. Stander, Fred J. Taussig, Herbert Thoms, Paul Titus, Norris W. Vaux, W. H. Vogt, and Raymond E. Watkins.

JOURNAL DESK

Many of our members are moved about frequently by the Army and the Navy, as well as for other reasons as their requests for change of address to the Journal office testifies. The following are a few of the changes made since the May Journal was mailed:

Major Roy VanDeventer, formerly of Wellington, and for a time with the Kansas Medical Officers Recruiting Board in Topeka, is now a Lieutenant Colonel with the 124the Station Hospital at Camp Carson, Colorado.

Lt. Clyde W. Miller has been transfered from Camp Beauregard, Louisiana, to the Station Hospital at Fort Clark, Texas.

Capt. Lloyd K. Harton, formerly of Salina, is at Santa Ana, California.

Dr. Guy R. Blackburn, formerly with Santa Fe Hospital in Topeka, is now in Fort Madison, Iowa.

Lt. Leteer Lewis has recently been transfered from Denver, Colorado, to Jefferson Barracks, Missouri, and then to San Francisco, California, with an APO address.

Lt. Col. Ralph G. Ball, formerly of Manhattan, is with the 99th Evacuation Hospital at Camp Shelby, Mississippi.

Lt. Comdr. D. A. Ward has been transferred from Norman, Oklahoma, to San Francisco, California.

Dr. J. F. Edwards has recently moved from Seattle, Washington, to Kansas City, Missouri.

Capt. Alfred H. Hinshaw, formerly of Kansas City, is now a Major and stationed at Fort Snelling, Minnesota.

Dr. S. N. Mallison of El Dorado, has recently moved to Harrisburg, Illinois.

Lt. Comdr. James S. Hibbard, formerly from Wichita, is now with the United States Navy with a Fleet Post Office address out of San Francisco, California.

Dr. Samuel Thierstein, formerly of Lindsborg, is now in Chicago, Illinois.

Lt. Charles T. Sills, formerly with the Axtell Clinic in Newton, has recently been promoted to a Captain and is stationed at Fort Bliss, Texas.

BLIND PROGRAM

Dr. W. W. Reed, state supervising opthalmologist for the Kansas State Board of Social Welfare, recently issued the following report pertaining to examination and treatment furnished under the Kansas blind program as of April 30, 1943:

AID TO THE BLIND

	April	1943	To Date
New Applicants—Approved	16	42	2726
Ineligible	5	34	2031
	21	76	4757
Re-Examinations—Re-Certified	4	15	
Newly Eligible	0	6	
Still Ineligible	0	5	
Newly Ineligible	0	1	
Again Eligible	0	1	
	4	28	
Total Examinations Given	25	104	5508
Total New Approvals for A.B.	21	55	

RESTORATION OF SIGHT

Recommendations for Treatment—New Cases	6	17	
Re-Examination	3	6	
	9	23	1242
Cases Under Treatment	105		
Completed Treatment Cases			
Eligible for A.B.	2	27	
Less: Re-Opened Cases	—0	—4	
	2	23	266
Ineligible for A.B.	2	26	
Less: Re-Opened Cases	—0	—2	
	2	26	470
Total Completed Cases	4	49	736

RECOMMENDATIONS FOR TREATMENT

New			3	12	675
Cases under Treatment			51		
Completed Treatment Cases					
Eligible for A.B.			0	0	12
Ineligible for A.B.	4	5			
Less Re-Opened	—2	— 3	2	27	474

COUNTY SOCIETIES

The Finney County Medical Society and the Kansas Crippled Children's Commission sponsored a clinic in Junction City on May 7. Assisting the members of the society at the clinic were: Dr. F. E. Coffey of Hays and Dr. C. B. Francisco of Kansas City.

The members of the Johnson County Medical Society, the Wyandotte County Society and the Jackson County, Missouri, Society were the dinner guests of the Olathe Naval Air Station on May 13. Commander Bruce V. Leamer is the senior medical officer. Guests were taken on an inspection tour of the base hospital, and a tour of the base in Navy buses. Base Commanding Officer Captain Dixie Kiefer gave a brief talk, and Dr. Logan Clendening of Kansas City, Missouri, gave the main talk.

The Labette County Medical Society held a meeting in Parsons on May 26. Dr. Fred Mayes of the Kansas State Board of Health at Topeka spoke on "Infantile Paralysis."

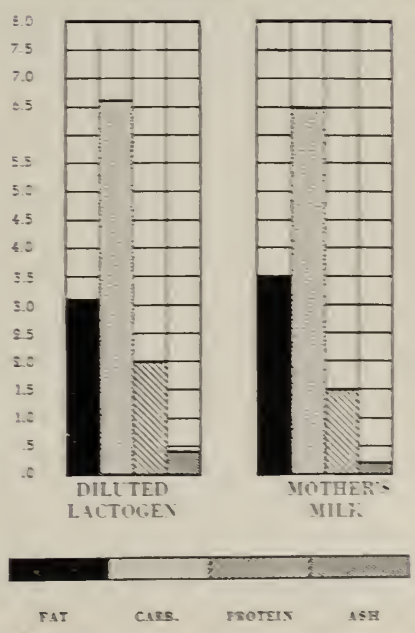




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"My own belief is, as already stated, that the average well baby thrives best on artificial foods in which the relations of the fat, sugar, and protein in the mixture are similar to those in human milk."—John Lovett Morse, A.M., M.D., Clinical Pediatrics, p. 156.

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At the May 4 meeting of the Sedgwick County Medical Society held in Wichita, the following new officers were elected for the coming year: Dr. A. W. Fegtly as President; Dr. J. S. Reifsneider as Vice-President; Dr. L. K. Nix as Secretary; Dr. A. L. Ashmore as Treasurer; Dr. H. R. Hodson, Dr. J. W. Shaw, and Dr. J. V. Van Cleve as members of the Board of Directors; and Dr. F. J. McEwen as a member of the Board of Censor. All the new officers will assume their duties on January 1, 1944. The program for the meeting was as follows: Lt. Abraham J. Kauver, M.C. of Camp Phillips, spoke on "Use and Abuse of Chemotherapy," and a motion picture on "Lyovac-Normal Human Plasma," was shown by courtesy of Sharp and Dohme.

The members of the Shawnee County Medical Society were hosts to the medical staff of the Winter General Hospital and the Topeka air base at the Shawnee Country Club on May 13. Lt. Col. Herbert C. Merillat surgeon of the air base hospital, Lt. Col. Milford T. Kubin, executive officer of the Winter General Hospital, and Lt. Henry Blake home on sick leave from the South-west Pacific war zone were the speakers. At the April 29 meeting Dr. Robert Hughes Parry, medical officer to the Bristol City Council, Bristol, England, gave his experiences as a doctor in an air raid. Bristol was heavily bombed in 1941.

The Wilson County Medical Society held a meeting in Fredonia on May 3. Following the business session the members were entertained ar the Flack home in honor of Dr. A. C. Flack's eighty-fifth birthday.

The final summer session of the Wyandotte County Medical Society was held at the Chamber of Commerce rooms on May 18. Dr. Z. Miles Nason, Dr. Theodore Steegmann and Dr. E. F. DeVilbiss discussed, "Practical Aspects of the Treatment of Alcoholism." By courtesy of the Upjohn Company a film on "Adrenal Cortex" was shown.

A staff meeting was held at the Winter General Hospital in Topeka on May 24, at which the members of the Shawnee County Medical Society were guests. Dr. Reuben L. Kahn, Director of the Clinical Laboratory of the University Hospital and serological consultant of the University of Michigan Medical School at Ann Arbor, Michigan, was the speaker. Dr. Kahn is also a consultant to the United States Public Health Service.

MEMBERS

Lt. Henry S. Blake of Topeka, is at home on sick leave with his family following a long period of service as battalion surgeon in the Southwest Pacific with a marine regiment.

Major Samuel T. Caughlin, formerly of Larned, and stationed first at Randolph Field, Texas, and then at Enid, Oklahoma, is now post surgeon of the Dodge City army air field station hospital.

The resignation of Dr. S. N. Mallison as county health officer of Butler County was accepted as of May 1. Dr. Mallison has accepted a position as superintendent of the Southern Illinois Health District with offices in Harrisburg, Illinois.



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Dr. F. R. Croson of Clay Center, was recently appointed city health officer of that city.

Dr. J. W. Neptune of Salina, has recently moved to Hutchinson where he will be connected with the hospital of the air base.

Dr. Joseph W. Spearing, former medical director of the Kansas Ordnance Plant in Parsons, has resigned his position as director and has returned to Columbus where he will enter private practice.

Lt. G. F. Helwig now stationed in Salt Lake City, Utah, has recently been at home in Topeka for a short leave.

Major Don C. Wakeman of Topeka, has recently finished a three months course at the Mayo Clinic and will return to Whiteside Hospital at Fort Riley on June 20.

Lt. Comdr. C. H. Warfield of Wichita, now stationed at the Great Lakes Training Station, gave a film demonstration of "Virus Pneumonias and Their Complications," at the 103rd Annual Meeting of the Illinois State Medical Society held in Chicago on May 20.

Dr. J. J. Michalak of Humboldt, has recently completed a postgraduate course at Ann Arbor, Michigan.

Dr. F. C. Tyree, who formerly lived at Wayne, is now located at Agenda.

DEATH NOTICES

Dr. Walter D. Bishop, 56 years of age, died on May 21, in Kansas City, of coronary thrombosis. He was graduated from the Emory University School of Medicine at Atlanta, Georgia, in 1915 and served in the Medical Corps during the World War. He was an active member of the Wyandotte County Medical Society.

Dr. Herman P. Daniels, 74 years of age, died on May 7, of cerebral thrombosis and myocardial degeneration at his home in Wichita. He was graduated from Northwestern University Medical School, Chicago in 1896. He was an honorary member of the Sedgwick County Medical Society.

Dr. William Roy Dillingham, 59 years of age, died on May 13, of uremia and nephrosclerosis in Wichita. Dr. Dillingham's home was in Salina. He was born on November 9, 1883, in Hiawatha, was graduated from the University College of Medicine in Kansas City in 1908, and was a Captain in the Medical Corps during the World War. He was a member of the Saline County Medical Society.

Dr. Emma L. Hill, 84 years of age, of Oswego, was injured in an auto accident from which she died on May 15. Dr. Hill was on a professional call when the accident occurred which caused her death. She was graduated from the Kansas College of Medicine in Topeka in 1895 and attended the University of Illinois School of Medicine from which she graduated in 1902. She was an active member of the Labette County Medical Society.



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. . . how S-M-A eliminates many unnecessary questions that mothers usually ask about other modified milk formulas.



When I had finished, she said she would certainly speak to George about using S-M-A as a routine formula.

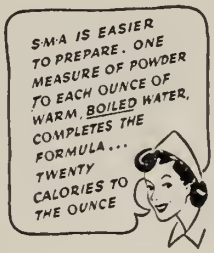
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Dr. Walton H. Rea, 65 years of age, retired Arkansas City physician, died of cerebral hemorrhage in Topeka on May 26. He was born on August 7, at Meredosia, Illinois, and was graduated from the Barnes Medical College in 1905. He was an honorary member of the Shawnee County Medical Society.

Dr. Leslie Chapman Tilden, 76 years of age, died on May 17, of carcinoma of the liver, stomach and pancreas at his home in Oberlin. He was born on July 31, 1866, in Enfield, Connecticut, and was graduated from the New York University Medical College of New York in 1889. He was a member of the Northwest County Medical Society.

OFFICIAL PROCEEDINGS

EIGHTY-FOURTH ANNUAL MEETING OF THE KANSAS MEDICAL SOCIETY

Minutes of the First Session of the House of Delegates

The first regular session of the House of Delegates was held at the Hotel Jayhawk in Topeka on Saturday, May 9, 1943, commencing at 8:30 p. m., Dr. Henry N. Tihen, President, presiding and calling the meeting to order.

Explanation was made of the functions of the Sergeant-at-Arms, Dr. Arthur W. Fegtly, and of the Reference Committee consisting of Drs. Charles R. Rombold, Arthur Fegtly and John L. Grove.

Motion was duly made, seconded and passed that the reading of the minutes of the last meeting be dispensed with.

Dr. Rombold read the report of the Reference Committee and moved its acceptance; seconded by Dr. Lattimore. The motion carried.

Dr. A. W. Fegtly of Wichita announced that the voting strength of this session of the House of Delegates was seventy-eight votes.

The report of the Reference Committee on Officers and Councilors Reports and on Committee Reports and Resolutions was presented by Dr. Charles Rombold, Chairman, who moved that they be accepted. The motion was seconded by Dr. J. L. Lattimore and carried. The reports adopted were as follows:

Dr. Tihen asked that all members stand with bowed heads for one minute in memory of departed members. (Necrology report in April Journal).



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Topeka, Kansas

Dr. Duncan thanked Drs. Lattimore, Tihen and Loveland for their excellent assistance to his Committee on Public Policy.

Mr. Robert Brooks was introduced and read the Executive Secretary's report. Upon a motion by Dr. Bernstorf, duly seconded and carried, the report was accepted.

Report of the Constitutional Secretary, Dr. F. R. Croson, was read and approved. (Published in April issue of the Journal).

The Treasurer's report was read by Dr. George M. Gray. He expressed the opinion that the balance of the special contributions fund should be turned over to the treasurer and perhaps used to buy government bonds.

It was moved by Dr. Gsell, seconded by Dr. Bernstorf, that the Treasurer's report be accepted as read with the exception of the matter of the special contributions fund which should be referred to the Council for action.

Report of the Journal of The Kansas Medical Society by Dr. W. M. Mills, Editor, was approved as read. A rising vote of thanks was tendered to Dr. Mills and Mrs. Mateel F. Todd, Business Manager of the Journal, for their fine work.

Dr. Forrest L. Loveland reported on Procurement and Assignment, urging every member present to remind his fellow doctors at home to fill out and send in the re-classification cards which were sent to them.

Dr. Tihen read his report of his year as President. It was approved and a rising vote of thanks tendered to him.

An advertisement of a medical encyclopedia written by Dr. Morris Fishbein was displayed and there was considerable discussion as to the propriety of such an advertisement in magazines and newspapers.

Dr. Tihen presented for consideration a Resolution from the National Conference on Medical Service requesting the adoption of a stronger legislative policy by the American Medical Association, including the establishment of a permanent Washington office. Considerable discussion followed by Drs. Duncan, Gsell, Nesselrode, Ebright and Lattimore. It was moved, seconded and carried that Dr. Tihen appoint a committee to investigate this matter further and present their findings at the second session of the meeting. The Committee was appointed consisting of Dr. Warren F. Bernstorf, Chairman, Dr. J. F. Gsell, Dr. C. C. Nesselrode, Dr. Walter E. Stephenson and Dr. John L. Lattimore.

Dr. Tihen reported that the American Medical Association has had very little material or help to offer in aiding the State Medical Society in its efforts to oppose the lowering of medical standards by the cultists. He presented the following Resolution:

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

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"WHEREAS, These cultists and their schools have arisen as healing methods opposed to the use of medicine and surgery, and

"WHEREAS, The licensed practitioners of these healing arts are in ever-increasing numbers practicing medicine and surgery, often illegally, and

"WHEREAS, The American Medical Association has not furnished any leadership in the development of ways and means of opposing the ever-increasing legislative demands of these cultists in Congress and in the various state legislatures every year, and

"WHEREAS, This is resulting in a lowering of the standards of medical practice in many states because of the admission in various degrees to the practice of medicine and surgery by the cultists, especially the osteopaths, whereby the osteopathic schools become in effect diploma-mills for the practice of medicine and surgery, and

"WHEREAS, The Kansas medical profession rejects the



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idea that any of the cultists are qualified to practice medicine and surgery;

"Be it resolved, That the proper department of the American Medical Association be suitably expanded to acquire the material and develop suitable means to combat this evil of legislative recognition of the cultists to participate in the practice of medicine and surgery for which they are unqualified, and

"Be it further resolved, That this material and methods of combating this evil be effectively used in Congress and, through cooperation of the various state medical societies, in the state legislatures, and

"Be it further resolved, That the American Medical Association take a more active and effective leadership, which it has so far not exhibited, in upholding the rights of the public to protection against the admission of cultists, with their lack of qualifications, to the practice of medicine and surgery or any part thereof."

It was moved by Dr. Peck, seconded by Dr. Ebright, that the Resolution be approved and presented by our American Medical Association Delegates at the American Medical Association meeting in Chicago in whatever manner would be the most effective.

Dr. Tihen read a list of the districts which required new councilor elections and announced a request for a short meeting of the Sixth District Delegates after this meeting.

Second House of Delegates meeting was announced.

Dr. H. R. Hodson introduced the subject of nursing care and the possibility of a shortage of nurses in Kansas. Upon a motion duly made and seconded and carried, this subject was referred to the committee on Allied Groups of The Kansas Medical Society for study.

Adjournment followed.

EIGHTY-FOURTH ANNUAL MEETING OF THE KANSAS MEDICAL SOCIETY

Minutes of the Second Session of the House of Delegates

The second session of the House of Delegates convened at 9:30 a. m. in the Florentine Room of the Hotel Jayhawk on May 9, 1943.

The first order of business was the report of the special committee headed by Dr. Bernstorf. The Committee had investigated the Resolution prepared by the National Conference on Medical Service and reported that this National Conference was the outgrowth of a number of efforts made for some years to promote a stronger legislative policy by the American Medical Association. Representatives of twenty-nine states met in Chicago in February and formulated this Resolution, which has been sent out to all state societies. Dr. W. L. Burnap, President of the Council of the Minnesota State Medical Society, was elected President and Dr. C. L. Palmer of Pitts-

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burgh, Pennsylvania, was elected Secretary of this National Conference. The Committee presented the following written report:

Gentlemen:

The Committee which your President appointed in regard to the Resolution of the Medical Service Committee, wishes to make the following report:

This Committee recommends that the House of Delegates of The Kansas Medical Society go on record as favoring the principles as expressed in the Resolution which the Minnesota State Medical Society will present to the House of Delegates of the American Medical Association, which contemplates the creation of a Medical Service Committee by the American Medical Association.

Therefore, be it resolved, That the House of Delegates of The Kansas Medical Society in session assembled at Topeka, Kansas, May 8, 1943, directs their delegates to the American Medical Association to support such a Resolution.

Warren F. Bernstorf, M.D., *Chairman,*
C. C. Nesselrode, M.D.,
John L. Lattimore, M.D.,
W. Stephenson, M.D.,
J. F. Gsell, M.D.

It was moved and seconded that the report be adopted. Motion carried.

Dr. Tihen presented the subject of the practice of medicine and surgery by the cultists, mentioning the large number of complaints that he has received that the medical practice laws are not being enforced. The question was thoroughly discussed by Dr. Hassig, Dr. Duncan, Dr. Mayer, Dr. Loveland, Dr. Callahan, Dr. Cave, Dr. Barney, Dr. Brawley, Dr. Gsell, Dr. Rombold and Dr. Tihen. A motion was made, duly seconded and passed by the House of Delegates requesting active enforcement of medical practice laws and active prosecution of the violators thereof. The details of the above discussion and above motion are on file in our central office.

Dr. Nesselrode discussed the question of civilian medical care and suggested that the medical profession emphasize the fact that adequate medical care for the home front will be maintained.

Dr. Tihen expressed his personal appreciation to Drs. Loveland and Lattimore for their time and help during the legislative session.

The House of Delegates then proceeded to the election of officers and councilors. Dr. Marion Trueheart of Sterling, was elected President-Elect for 1943-44; Dr. W. P. Callahan of Wichita, was elected First Vice-President; Dr. W. M. Mills of Topeka, was elected Second Vice-President; Dr. F. R. Croson of Clay Center, was elected Secretary; Dr. Geo. M. Gray of Kansas City, Kansas, was elected Treasurer; Dr. F. L. Loveland of Topeka, was elected as American Medical Association Delegate for 1944 and 1945; Dr. C. H. Benage of Pittsburg, was elected as Councilor for the Third District; Dr. W. F. Bernstorf of Winfield, was elected as Councilor for the Sixth District; Dr. O. A. Hennerich of Hays, was re-elected as Councilor of the Tenth District; Dr. G. R. Hastings

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

of Garden City, was elected as Councilor of the Twelfth District. It was moved and seconded and carried that Dr. Campbell be elected to the office of Councilor of the Eleventh District in his absence because of the present war emergency and the difficulty of getting to the State meeting.

The expenses of the two Delegates, the incoming President and Mr. Brooks were authorized for attendance at the annual American Medical Association meeting.

Dr. Lattimore was then installed as President for the ensuing year.

Adjournment followed.

COUNCIL MINUTES

A meeting of the Council was held in Topeka at the Hotel Jayhawk on May 9, 1943. Those present were: Dr. J. L. Lattimore of Topeka, president; Dr. Henry N. Tihen of Wichita, Dr. Marion Trueheart of Sterling, Dr. W. P. Callahan of Wichita, Dr. W. M. Mills of Topeka, Dr. F. R. Croson of Clay Center, Dr. Geo. M. Gray of Kansas City, Dr. Forrest L. Loveland of Topeka, Dr. J. F. Hassig of Kansas City, Dr. J. W. Randell of Marysville, Dr. O. W. Davidson of Kansas City, Dr. C. H. Benage of Pittsburg, Dr. Philip W. Morgan of Emporia, Dr. John L. Grove of Newton, Dr. R. R. Cave of Manhattan, Dr. Ben H. Mayer of Ellsworth, Dr. J. H. A. Peck of St. Francis, Dr. O. A. Hennerich of Hays, Dr. L. S. Nelson of Salina, and Dr. G. R. Hasting of Garden City.

The first order of business was the yearly report of the Defense Board's activities, given by Dr. L. S. Nelson of Salina.

A very thorough and comprehensive discussion was held of the Society's legislative needs, stressing the advisability of the passage of a new medical practice act to replace the one in effect since 1858. It was suggested that a committee be appointed by the president to study the establishment of a continuous legislative program and to bring the result of such investigation before the next council meeting. Every councilor district will be asked to furnish a legislative candidate.

Dr. E. H. Decker of Topeka was elected to take the place on the Editorial Board, of Dr. R. B. Stewart, who has moved to California; Dr. R. P. Knight of Topeka elected to take the place of Dr. L. E. Eckles, in army service.

The matter of a state meeting in 1944 was left until the January meeting of the council.

Dr. J. H. A. Peck asked for continued and increased support of the University of Kansas School of Medicine. "Junior" memberships for interns were discussed.

There being no further business, adjournment followed.

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MRS. E. N. ROBERTSON, Concordia Treasurer

PRESIDENT'S MESSAGE

The Woman's Auxiliary to the Kansas Medical Society under the leadership of its president, Mrs. C. Omer West, has completed a very successful year. Each county gave an encouraging report of Auxiliary work accomplished. All but three of the organized counties were represented at the state meeting.

Your delegates and president are preparing to attend the National Auxiliary Meeting in Chicago. From this national meeting we hope to bring back new inspiration and plans for the coming year's work. These suggestions will be forwarded to the county units just as soon as the state chairmen can get them compiled.

Thru the summer is the time for the county presidents and chairmen to outline their year's work, before other activities start in the fall, then no valuable time is lost. Many mistakes can be avoided by planning, then thoroughly digesting these plans before putting them into operation.

There are so many worthwhile calls upon the auxiliaries, each must decide for itself just how much it can do. Now is a great opportunity for the public relations chairmen. It is to be hoped each county has an active committee. We are not stressing organization during the war, but we must keep our identity, looking foreward to peace times. The doctor's wife has a place to fill that no one else can fill, and if she neglects her opportunity no one will do it for her.

May your president suggest again the need of concern to be taken in our country's young people? Since the closing of the schools for the summer many juveniles not working or in summer schools need something to keep them interested and busy. Supervised playgrounds and handcrafts may be the answer in some neighborhoods. Other projects may be worked out elsewhere. Let us as Auxiliary members give some thought to this problem.

Until after the national convention,

Mrs. E. E. Tippin

AUXILIARY NEWS

The Women's Auxiliary to the Sedgwick County Medical Society held a luncheon in Wichita on May 10 at the Innes Tea Room. Mrs. N. C. Nash, president for 1942-1943 presided and Mrs. D. W. Basham installed the new officers for 1943-1944.

The Labette County Auxiliary held a meeting in Parsons on May 26. The new officers are as follows: Mrs. J. T. Naramore of Parsons, is president; Mrs. J. A. Ebert of Oswego, is president-elect; Mrs. N. C. Morrow of Parsons, is vice-president, and Mrs. T. D. Blasdel of Parsons, is secretary-treasurer.

The members of the Shawnee County Auxiliary entertained their husbands and the members of the Shawnee County Medical Assistant's Society with a picnic on June 17, at Lake Shawnee.

Mrs. P. E. Belknap entertained the members of the Shawnee County Auxiliary on May 3 with a desert-meeting. Assisting hostesses were: Mrs. E. H. Decker, Mrs. G. L. Kerley and Mrs. O. A. McDonald.

Regional Director J. M. Loughlin of the first civilian defense area recently announced the formation of a parachute corps to drop doctors and nurses to stricken areas in out of the way places. The corps was organized by the Civil Air Patrol in New England under the direction of Major R. S. Fogg, regional commander of the Civil Air Patrol, on the rolls of which already are twenty-five doctors and thirty nurses, some of whom own their own airplanes, according to the Boston Blobe.—Illinois Medical Journal.

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STATE PROCUREMENT AND ASSIGNMENT

Frank H. Lahey, M.D.*

Boston, Massachusetts

If all the states in the Union had met their quotas for physicians as has Kansas, the problems of the Central Board of the Procurement and Assignment Service in Washington would be simple. Kansas, as is well known, met its 1942 quota by 119 per cent. In other words, it subscribed nineteen per cent more physicians than were requested for 1942. The 1943 quota of physicians is seventy-eight, of which it has now supplied thirty-two, or forty-four per cent of its 1943 quota in the first three months of the year. This is an admirable record, and not only one of which the state can be proud but also one which reflects credit upon Dr. Loveland, the state chairman of the Procurement and Assignment Service, the members of the Procurement and Assignment Board, and the members of the district and county boards. This last group of men, to whom is often given all too little credit, has worked industriously and has done much to supply valuable information concerning physicians.

The established state quotas for 1942 have been well met as far as the country as a whole goes, that is, in terms of the total number of doctors requisitioned by the armed forces and the total number supplied. This is a praiseworthy performance on the part of medicine, since it has been accomplished entirely upon a voluntary basis. Unfortunately, as is so apt to occur when a project of this magnitude is undertaken upon a voluntary basis, inequalities and injustices in the remaining supply of physicians have resulted. Numerous reasons have been advanced as to why some states have oversubscribed their quotas and others have not met theirs. The fact remains. whatever the reason, that numbers above quotas have been supplied by some states in spite of remonstrances by the Central Board, and these oversubscriptions have resulted in injustices to the population within those states without a sufficient remaining number of physicians, and injustices in terms of physical hardship to the physicians themselves in the states depleted of physicians.

In such states as Alabama, Georgia, Kansas, Kentucky, Louisiana, Mississippi, South Carolina, Texas and several others, which have so adequately met their obligations, one can see demonstrated the difficulties created for the Central Board of the Procurement and Assignment Service. In other states there is an adequate number of men marked available to meet state quotas, but these states have not met their quotas because the doctors have not applied for commissions.

In some states, particularly those containing large cities, such as New York, Connecticut, California, Massachusetts and Wisconsin, 1942 quotas were not met. The total quota of doctors to be supplied in 1942 was 34,877. When one adds the deficits of 1942 to the quotas for 1943 in these under-quota states, the total is a considerable percentage of the number of physicians that should be supplied for the armed forces for 1943. Obviously, unless these available men in the under-quota states apply for commissions, the 10,705 physicians for 1943 will come out of states which have already generously subscribed their quotas and have remaining none too many physicians for the civilian population. If 10,705 physicians are obtained largely from regions other than those states below their quotas, a problem will be created which will greatly complicate the situation in that further depletion will occur in already depleted states and excess numbers will remain in states which have not met their quotas.

The situation can be explained frankly by a demonstration of its relationship to an individual doctor. If a doctor is marked available by the Procurement and Assignment Service, his first duty if he does not think he is available is to appeal his classification as is the case in the Selective Service draft. He can appeal to his state chairman, stating the reasons why he considers himself essential rather than available. If he fails to be supported in this position, he can appeal to his corps area chairman, and if he fails to obtain agreement from this agency, he can appeal to

* Chairman of the National Procurement and Assignment Board.

the Central Board in Washington. If there is any doctor, dentist or veterinarian who has been classified as available and requested to seek a commission who disagrees with his status of availability and who has not appealed his case, he certainly has not cooperated with what seems to me a most democratic plan of selection of physicians for the armed forces. If a man marked available by the Procurement and Assignment Service has neither sought a commission nor officially questioned his classification, he must admit a lamentable lack of interest in the war effort, the obligations of medicine, and his own personal duty.

I state the above example to clarify the crux of the national problem of state inequalities, and to emphasize the possibility of further injustices as we attempt to obtain upon a voluntary basis the 10,705 doctors needed by the armed forces for 1943.

In supplying the Army with medical personnel in 1943, it will be most unfortunate if what a large percentage of all physicians so patriotically have done in contributing their services to the armed forces is in any way discredited by a relatively small proportion who unfortunately are not only unwilling to volunteer but have not even been sufficiently interested to contest their classification when marked available. A state such as Kansas, which has done its duty so well, should also realize some of the difficult problems of the Procurement and Assignment Service in other states in which the program has not been met so gratifyingly.

One of the things that the Procurement and Assignment Service has been apprehensive about is the dislocation of physicians. There is little reward—none in terms of a uniform—and none even in terms of local recognition—for the physician who is willing to be dislocated, and often there are many hardships of a physical, professional and family nature. It will be of interest to the medical profession to realize that even in the face of these discouragements, there have now been dislocated over 1,100 physicians. Many of these men are well along in years and have been willing to be dislocated because they believe it is a really valuable contribution to the national effort. With their quiet and unpretentious patriotism, they deserve a great deal more credit than they have received.

These critical remarks are, I believe, but a healthy and frank revelation of some of our problems. As a whole, medicine, dentistry and veterinary medicine have made as laudable a contribution in meeting their obligation in this war as has any special group in the country. In spite of our difficulties in some of the larger cities consequent to a voluntary system, I still hope that the program will be continued upon that basis. I still believe that medicine can meet its obligations upon an entirely voluntary basis and I believe firmly that regardless of some disappointments, injustices and inequalities under this voluntary plan they are fewer and of less seriousness than they would be under a compulsory plan set up to capture an unpatriotic and reluctant few in the medical profession.

The willing and patriotic majority in medicine have cooperated wholeheartedly with this plan, and I doubt that there is any special group in this country which has foreseen its duties as well, planned its program as intelligently and executed it as effectively as have medicine, dentistry and veterinary medicine.

THE PROCUREMENT AND ASSIGNMENT SERVICE FOR PHYSICIANS, DENTISTS AND VETERINARIANS RESPONSIBILITIES, ACCOMPLISHMENTS AND FUTURE PROBLEMS

Harold S. Diehl, M.D.*

Minneapolis, Minnesota

A little more than a year has passed since October 30, 1941, when the President of the United States, by executive order, created the Procurement and Assignment Service for Physicians, Dentists and Veterinarians. The reason for this order was the realization that adequate medical and health services for both military and civilian populations are essential for the effective prosecution of a war. The action was taken upon the recommendations of the American Medical Association, the American Dental Association, the Surgeon Generals of the Army, the Navy, and the United States Public Health Service, and Mr. Paul V. McNutt, as Chief of the Office of Defense, Health and Welfare Services. This makes the Procurement and Assignment Service, morally at least, responsible both to the government of the United States and the medical, dental, and veterinary medical professions of this country. In view of this it is appropriate that a brief report should be made at this time of the accomplishments of this service to date and the problems and responsibilities remaining for 1943.

* Member, Directing Board, Procurement and Assignment Service and Dean of the Medical Sciences, University of Minnesota.

In general terms, the responsibility of this service is to plan for the distribution of the services of the physicians, dentists and veterinarians of this country so as to meet as effectively as possible the needs of both the armed forces and the civilian population during the war.

The plan of procedure contemplated by the Directing Board at its early meetings was to proceed in an orderly manner to appraise the medical personnel of this country, their qualifications, and their availability for military or civilian services in case of war. Unfortunately, the ink was hardly dry on the President's executive order before we were plunged into the midst of war. This made it necessary for the Procurement and Assignment Service to formulate policies, develop its organization, and begin to function all at the same time. There was no blueprint to follow, no past experience upon which to draw.

ORGANIZATION AND ADMINISTRATIVE RELATIONSHIPS

Although its establishment antedated that of the War Manpower Commission, the Procurement and Assignment Service was made administratively responsible to that organization immediately upon its creation. This made the Procurement and Assignment Service what might be called the medical division of the War Manpower Commission. Although official channels between the Procurement and Assignment Service and the War and Navy Departments are through the Director of the War Manpower Commission, the vast majority of the relationships with the Army and the Navy are conducted directly and informally with the Offices of the Surgeon Generals of these services. In fact, the Directing Board of the Procurement and Assignment Service holds monthly meetings with the Surgeon General of the Army, the Surgeon General of the Navy, the Surgeon General of the United States Public Health Service, the Director of Selective Service and such members of their staffs as they elect to accompany them. The results of these conferences and informal relationships have been so satisfactory that very few communications through official channels have been necessary. Without this splendid understanding and effective cooperation on the part of these services, the task of the Procurement and Assignment Service would have been an impossible one.

The organization of the Procurement and Assignment Service consists of a Directing Board, a Central Office in Washington, a Consultant's office in the headquarters of the American Medical Association in Chicago, and Corps Area and State Committees, with local, county, or district committees serving in an advisory capacity. The physicians on these various boards and committees have given unselfishly and unstintingly of their time and services. Without compensation, at great personal sacrifice, and at times in spite of uniformed or malicious criticism. these men have rendered and are continuing to render an invaluable and patriotic service to our country in its war effort. It is primarily to the chairmen and the members of state and local Procurement and Assignment Service committees that the real credit for the accomplishments of this service belongs.

With the American Medical Association and the various state medical societies, the Procurement and Assignment Service has a most intimate, though unofficial, relationship. In 1940 the American Medical Association at great expense and effort prepared a roster of all the physicians in the United States with detailed information in regard to their training, experience and qualifications. This invaluable roster was made available to the Procurement and Assignment Service immediately after its organization. In addition, the American Medical Association has made its staff and facilities available at all times to aid in the work of the Procurement and Assignment Service. In like manner, state medical societies not only have cooperated wholeheartedly, but in many instances have provided a large portion of the expenses and carried much of the work and the state and local Procurement and Assignment committees. Without this assistance and support, the work of the Procurement and Assignment Service could not possibly have been carried out. To these various medical associations we acknowledge our deep indebtedness.

ACCOMPLISHMENTS OF 1942

With the rapid expansion of our armed forces last year, the first responsibility of the Procurement and Assignment Service was clearly to cooperate with the Army and the Navy in the recruitment of the medical officers which they needed. Our boys, and now our girls, whether they be in Africa, India, Guadalcanal, Australia, Alaska, or the continental United States, must be provided with the best of medical care. I am sure that everyone would agree that the provision of medical services to those who are risking and in many cases sacrificing their lives in defense of our country deserves first priority in the allocation of physicians.

Second, probably, comes the need of the medical schools for teachers to train more physicians under the accelerated program of medical education. These institutions, which have been mobilized 100 per cent for the war effort, serve as the only source of supply for additions to or replacements of physicians for both the armed forces and the civilian population.

Next, in order of priority, comes the provision of

medical care for workers in the war industries. These workers must be kept on the job, producing the materials of war without which armies and navies are helpless in modern warfare.

This leaves as last on our priority list the needs of the general population for medical services. This does not mean that the civilian population will have to get along with what is left after the armed forces, the medical schools and the war industries have taken all the physicians that they want. The effective prosecution of a modern war requires the mobilization of the entire resources of the nation in support of the war effort. Under such circumstances, it is clearly necessary that a sufficient number of physicians be retained to provide essential medical services for the civilian population. Recognizing this, the Army and the Navy have agreed not to grant commissions to physicians declared essential by the Procurement and Assignment Service for civilian medical care. Likewise, local Selective Service boards have been directed by National Headquarters to secure the recommendation of the Procurement and Assignment Service whenever they are considering the classification of a physician, dentist or veterinarian.

RECRUITMENT OF PHYSICIANS IN 1942

At the outbreak of war there were approximately 13,000 medical officers on duty in the Army and the Navy. At the end of 1942, approximately one year later, this number had increased to over 42,000. The recruitment of such a large number of physicians in a short period of time was a colossal undertaking. Except for a few single men who came under the jurisdiction of Selective Service, there was no authority to compel physicians to go into the Service. What has been accomplished has been entirely on a voluntary basis. The Procurement and Assignment Service possesses no authority to say to a physician that he must go into the service or that he must stay at home. Some of the Army recruiting boards in their zealous efforts to recruit physicians presumed and even threatened to use authority which they did not possess. Actually neither these boards nor the Procurement and Assignment Service has authority to exercise compulsion upon anyone.

Early in last year it seemed for a time that physicians were slow in responding to the call for their services. But by the end of the year, over fifty per cent of the practicing physicians under forty-five years of age had entered the armed services. No other professional group in this country has ever been called upon for such public service or responded to a call so magnificently.

During the first world war, the recruitment of physicians for the Army and Navy was carried on with little or no consideration for the needs of the civilian population. Many areas and communities were left without medical service, while in other areas excessive numbers of physicians remained in civilian life. To help prevent a similar situation this time, the Procurement and Assignment Service established quotas as to the number of physicians which each state was expected to supply in 1942. These quotas represented the proportionate share of the 42,000 medical officers requested by the armed forces, which it seemed equitable for each state to provide, taking into consideration the population of the state, the number of physicians in civilian practice, their ages, distribution, etc. These quotas for states with relatively few physicians in relation to population required only ten to fifteen per cent of the practicing physicians; while at the other end of the scale, the quotas of states such as New York and Illinois represented up to thirty per cent of the physicians actively engaged in civilian practice.

The country as a whole and all but five individual states met or exceeded the quotas assigned to them for 1942. From a few areas, particularly in the South, too many physicians have gone into service, leaving the civilian population without adequate medical care. Some of these physicians held commissions in the Reserve Corps of the Army or Navy and were called to active duty; others volunteered early before the Procurement and Assignment Service program became operative; others were released by the State Procurement and Assignment Committees because it seemed that there were sufficient numbers of doctors remaining to care for the civilian population. In some instances, these calculations were upset by illness or death among the remaining physicians or by the unanticipated influx of large populations in connection with war industries or war activities. I know of one county in which there were three physicians. The youngest of these was declared "available" for military service. Subsequently one of the two remaining physicians has died, and the other has had a "coronary attack," which seriously limits his availability for practice. The result is that this county is now critically short of medical service.

THE MAINTENANCE OF CIVILIAN MEDICAL SERVICES

In order to safeguard civilian medical services, the chairmen of the State Procurement and Assignment Committees have been directed to designate as "essential" those physicians considered necessary for the provision of essential civilian medical services.

To aid in this, medical schools have been authorized to submit lists of their faculty members, marking as "available" those whom they could release for

service with the armed forces but listing as "essential" those who constitute the minimum staff necessary to conduct a sound teaching program. These reports specify the subjects that each individual is teaching and the amount of time he was devoting to such teaching. All lists of "essential teachers" as submitted by the medical schools are reviewed by the Medical Education Committee and the Allocation Committee of the Procurement and Assignment Service. The opinion of these committees in regard to the lists is then sent to the chairmen of the respective State Committees who are responsible for decisions as to who is "available" and who "essential." The objective is to retain adequate teaching staffs for the medical schools, but to do so without withholding from military service more than the minimum number of men who are physically qualified for military service.

Analysis of the medical school lists which were submitted last summer for the current academic year showed that up to that time twenty-one per cent of the physicians on medical school faculties were in Army or Navy service as compared to twelve per cent of all the physicians in the United States. In addition, the medical schools listed as "available" twenty-five per cent of the physicians of military age remaining on their staffs.

Industrial medical service assumes increasing importance in connection with the war. The criteria as to the conditions under which physicians in industry should be considered "essential" were prepared by the Committee on Industrial Health of the Procurement and Assignment Service. This Committee recommended that essential industrial medical services be continued but that physically fit young physicians of military age serving in industry should be replaced as rapidly as possible by those who are not physically fit or otherwise ineligible for military service.

Public health services must be maintained for the protection of the health of the armed forces as well as of the civilian population; yet the staffs of these services contained many physicians with training and experience urgently needed by both the Army and the Navy. Epidemiologists, parasitologists, bacteriologists, statisticians, and public health administrators are urgently needed for the prevention and control of diseases among our soldiers who are serving in all parts of the world. In order that public health services might be maintained and yet as many as possible of these specialists relieved, all state, city and county health departments were requested to prepare lists of personnel, indicating which ones of military age could be released for military service and which ones are considered as essential for the effective functioning of the health department. These lists are reviewed by the Public Health Committee of the Procurement and Assignment Service.

Hospitals. Most of the members of the clinical staffs of hospitals are physicians practicing in the community and are designated as "available" or "essential" on the basis of the importance of their services to the community as a whole rather than to any individual hospital. On the other hand, in many of the large charity and teaching hospitals, certain residents and physicians in charge of special services, such as the x-ray and laboratory departments, are essential both for the clinical instruction of medical students and for the adequate care of the hospital patients. With this group the problem again is to release as many as possible for service with the armed forces and still retain the minimum number essential for the proper functioning of the institution. To accomplish this, hospitals approved for residencies have been requested to prepare lists of residents and other physicians who were on full time status or chiefs of large charity services, indicating those whom they consider to be the minimum essential staff of the hospital. These lists have been reviewed both by the Hospital Committee and the respective State Committees of the Procurement and Assignment Service.

"Boom Towns." During the past year many towns have experienced a mushroom growth as a result of war industries or military or naval installations. Some of these have given rise to critical shortages of medical services. Numerous articles have been written about these areas, frequently with gross exaggerations as to their number and seriousness. In many instances the workers in these war industries are recruited from persons already residing in the area. In others, if the influx of population is not excessive, the physicians in the community are able to provide the necessary medical care. On the other hand, there are a number of areas in which the shortage of medical services is truly critical. I have visited one community which in a little more than a year has grown from 15,000 to 65,000 population and it is expected that by July, 1943, the increase will reach 110,000. Another area which had approximately 40,000 population before the war now has 110,000 and is expected to have 145,000 by mid-summer. In the country as a whole, there are a number of such areas.

Last summer and fall a number of agencies in Washington became concerned about the shortage of medical services in these areas, and numerous conferences were held to define lines of responsibility and to outline procedures to deal with the situation. On the basis of these conferences, the Directing

Board of the Procurement and Assignment Service formulated certain policies in regard to the investigation of the need and the provision of medical care in critical shortage areas. These policies, which were approved by the United States Public Health Service, by the Trustees and the War Participation Committee of the American Medical Association and by the War Manpower Commission, placed the primary responsibility for the investigation of these areas and for the formulation of plans to meet these needs upon the Procurement and Assignment Service and the local medical profession, with the cooperation and assistance of the United States Public Health Service. In approving these principles, the War Manpower Commission said, "This approval is given with the understanding that the plan places a grave responsibility on the organized medical profession. and that the Procurement and Assignment Service has the obligation of assuring that this responsibility is effectively discharged."

To meet these responsibilities, the Directing Board requested detailed reports from the State Chairmen concerning changes in population, the medical personnel, and the medical and health facilities available and needed in communities or areas in which there are war industries or war activities or in which there is a known or expected shortage of medical services. In investigating the needs of these areas, the State Procurement and Assignment Committees were advised to seek the "cooperation of the state medical societies, the state dental societies, the state health officers, of indusry, of organized labor, and of other agencies, such as the State Defense Council, which should be able to make significant contributions to the solution of this problem." In addition. the Surgeon General of the United States Public Health Service has directed the regional representatives of this service to cooperate in the conduct of these investigations.

When these investigations revealed a need for additional physicians or other medical or health facilities or personnel, the principles provided that: "Whenever possible civilian needs as determined by these committees should be met through local arrangements, resources, and agencies. In case assistance is needed for the organization, administration, or financing, of necessary medical services in these areas, the responsibility for formulating the plan best suited to each particular situation should devolve upon an agency which should include representatives of the state health department, the state medical society and the state dental society with the cooperation and support — financial and technical — of the appropriate federal agencies; the administration of such plans to be delegated to the appropriate official state agency." It is recognized that the United States Public Health Service is the federal agency which will be responsible for the provision of funds or personnel which may be required to provide the necessary health services in these areas.

In the formulation and execution of this program, there has been complete harmony and cooperation between the Directing Board of the Procurement and Assignment Service and the United States Public Health Service as represented by Surgeon General Thomas Parran and Assistant Surgeon General Warren Draper. Before the close of 1942, this program was inaugurated as a cooperative enterprise between the medical profession, the Procurement and Assignment Service, and the United States Public Health Service.

PROBLEMS OF THE PROCUREMENT AND ASSIGNMENT SERVICE FOR 1943

The end of the year means little in war except to provide a convenient point at which to end and begin reports. Similarily, the responsibilities and the problems which faced the Procurement and Assignment Service in 1942 carry over into 1943. Changes in emphasis occur, but these are gradual and related to the over-all situation. The recruitment of additional physicians to serve with the armed forces and the maintenance of essential civilian medical services are still our major responsibilities. During the past year, however, there have been important changes in the situation confronting us. A year ago we had what seemed to be an almost unlimited supply of physicians; the needs of the armed forces for medical officers appeared easy to fill; war industries were just beginning to draw workers and their families from far and wide; and there seemed no problem of providing medical care for the civilian population.

With the advent of 1943, an analysis of the physicians of the country revealed that the statement about our having 180,000 physicians was misleading; and that withdrawals from this group were already approaching the limit of the available supply. The figures show that we do have a total of approximately 180,000 physicians registered in the United States. Of these, however, approximately 15,000 occupy full-time positions in public health departments. medical schools, insurance companies, or other governmental or private agencies not engaged in the practice of medicine; 28,000 are over sixty-five years of age, and for planning purposes are counted as only one-third effective by the Procurement and Assignment Service; it is estimated also that approximately five per cent, or a total of 7,000 of the physicians under sixty-five are completely or partially ineffective; 3,000 are resident physicians in hospitals;

and approximately 42,000 were in the armed forces on the first of January. This leaves only about 94,500 effective physicians remaining in civilian practice. There are areas in most states which have never had more than one doctor to two, three, or even more thousands of people. We cannot hope to bring about the millenium in these areas during the war when there is an over-all shortage of physicians. On the other hand, in areas in which a shortage of physicians has been created by the war a ratio of 3,000 or more people per physician is considered by the Directing Board as probably constituting a critical situation. On a basis of this over-all ratio of one physician for 1,500 population, approximately 83,000 physicians are needed to provide essential medical services for the civilian population. This leaves only 11,500 physicians who can be considered as "available" from civilian practice in 1943 to enter the military services. In addition, between 4,000 and 5,000 hospital interns and residents will become available for military service during 1943.

RECRUITMENT FOR THE ARMED FORCES

On the basis of their established tables of organization, the authorized expansion of the Army and Navy in 1943 would require between 40,000 and 45,000 additional medical officers. In spite of this, both the Surgeon General of the Army and the Surgeon General of the Navy have accepted the above computations as to the number of physicians who can be safely withdrawn from civilian practice. This means that they will have to adjust their plans of organization and operation so as to get along with less medical officers than they consider ideal. Both the Army and the Navy, however, are willing to make these adjustments.

In accepting the recommendations of the Procurement and Assignment Service as to the number of physicians to be recruited from the civilian population in 1943, the Army and Navy have placed upon this Service, and through it upon the medical profession, the responsibility of recruiting available physicians up to this number.

As a guide in this recruitment, tentative state quotas for 1943 have been set up. These quotas are based upon the physician-population ration in the state after the 1942 quota was met. Credit was given for physicians recruited in excess of the 1942 quota. while deficits on the 1942 quota were added to the new quotas. According to these computations, fourteen states have no quotas and only fifteen states have quotas of more than a hundred physicians for 1943.

The fact that some of these states have had no second quotas does not necessarily mean that no more physicians from these states should enter military service. Even in those states in which there is an over-all shortage of physicians, there probably are metropolitan areas from which some physicians can and should be released. If other areas within these states are critically short of physicians, efforts should be made to induce some of the available physicians from the metropolitan areas to move into these shortage areas. If they are unwilling to do so, they should be declared available for military service and persuaded to apply for commissions.

As a basis for future planning, State Procurement and Assignment Committees have been asked to reappraise the physicians remaining in their states as to their availability or essentiality, their age, professional qualifications, physical capacity, and family responsibilities. As soon as these surveys have been completed, summary reports will be sent to the Central Office of the Procurement and Assignment Service, and revision of certain state quotas may be made.

RECRUITMENT PROCEDURE

The Procurement and Assignment Service proposed and the Army agreed that recruitment in 1943 should be done by the Procurement and Assignment Service instead of by Army recruiting teams. Briefly summarized, the procedure agreed upon is as follows: The State Chairmen submit monthly lists of available physicians to the Central Office. From this office letters are sent to these physicians, requesting them to apply for commissions and enclosing cards addressed to the State Chairmen, indicating their preference for Army, Navy, or Air Corps service. The names of those choosing Army service are sent to the nearest Army Officer Procurement Board, which supplies the necessary application forms and authorizes physical examinations. A similar procedure is followed for those who prefer to serve in the Navy. In case a physician does not apply for a commission when requested to do so, it is the responsibility of the Procurement and Assignment Service, in cooperation with the local medical society, to induce him to accept the assignment which he has been given.

Some predict that it will be difficult to secure the number of physicians agreed upon for the armed forces in 1943. They point out that most of those who really want to serve are already in service. This is doubtlessly correct, but we feel certain that many more physicians will be willing to go when they are told specifically and individually that their services are needed. For others some persuasion may be necessary. As a whole, the medical profession has responded magnificently to our country's call. It is but a very small minority who would place selfish interests above professional and patriotic responsibilities.

A few days ago, however, I heard of a young

physically fit physician who left a hospital residency to go into private practice. To one who asked him about army service, he replied that his draft board would defer him. Upon such individuals it would be possible for the Army, Navy, and Selective Service to exert pressure. To do so, however, would require the issuance of general directives that would reflect unfavorably upon the medical profession as a whole. It is our hope that medical societies will set up local committees to cooperate with the Procurement and Assignment Service in the recruitment of those physicians of military age who are considered available for service with the armed forces. As a specific plan of procedure it is recommended that the officers of county medical societies act as committees to make personal contact with these physicians who are requested by the Procurement and Assignment Service to apply for commissions.

The time has come when every physically fit, available physicians under forty-five years of age is needed to care for the boys who are risking their lives in the service of our country. Quoting a statement which Dean Thorald Sollmann of Western Reserve University made to a recent graduating class in his medical school: "The time has come when it doesn't matter much that someone else evades his obligation. Each must live with his own conscience; and he who has none is missing something. Patriotism is what you give, not what you get; and what you give, not what the other fellow gives or withholds. And if it should turn out, as it may in a topsy turvy world, that he gets the plums and you get the husks, well—, a good doctor can lead a useful and satisfying life anywhere and anytime without plums."

MEETING CIVILIAN MEDICAL NEEDS

The problem of civilian medical care are becoming increasingly acute as more and more physicians are taken into the armed forces. This country has more physicians in relation to population than any other country in the world, and there will be plenty available to provide essential, though not luxury, medical services for both the armed forces and for the civilian population if their services are properly distributed and utilized economically and efficiently. At the beginning of the war, there was approximately one effective private practitioner of medicine to every 1,022 persons in the United States. At the end of 1942 this figure had increased to one to 1,361, and by the end of 1943 it will be approximately one to 1,500. It is reported that England has one physician to approximately 230 persons in the armed forces and one physician to 2,700 in the civilian population. In this country the corresponding figures at the present time are approximately one to 150 for the armed forces and one to 1,400 for the civilian population. Germany is said to have approximately one physician to between 8,000 and 12,000 population. From this one can only conclude that the United States is relatively well off in terms of medical care both for the civilian population and for the armed forces.

As stated earlier, at the end of 1942 more than half of the practicing physicians under forty-five years of age in this country were in the Army or Navy. By the end of 1943 practically all of those remaining who are physically fit and can be spared from civilian practice will be required to meet the minimum needs of the armed forces. This is the age group which is most active in medical practice and carries the biggest load of medical care. With them no longer available, the public is certain to feel a shortage of medical care. These shortages, however, need not be serious if the services of the remaining physicians are utilized intelligently and efficiently.

To do this it is important that patients do not call physicians unnecessarily and that, so far as possible, when they need a doctor they make appointments in advance so as to conserve the physician's time. It will be necessary also for physicians individually and as a group to plan to provide the public with essential medical services, whether they be in the office, the hospital or the home. Most physicians will need to add to their already long hours. Many who have completely or partially retired from practice will have to "carry on" once again. And all will have to share the responsibility for the medical services, including house calls, which normally would be rendered by the physicians who are now in service.

Medical Schools. The students in medical schools are almost all members of the armed forces. Their education must be continued on an effective level. The lists of essential teachers submitted by medical schools indicate that some schools have already lost so many members of their faculties that it will be difficult, if not impossible, for them to conduct a satisfactory instructional program. Other schools have been more conservative and can release additional physicians in 1943 toward meeting the needs of the armed forces.

War Industries. The continued expansion of war industries is creating an increasing demand for physicians. The Procurement and Assignment Service and the Council on Industrial Medicine of the American Medical Association are attempting to cooperate with the war industries in securing the physicians which they need. Efforts are being made, however, to secure physicians for these industries who are not eligible for military service and to replace as rapidly as possible the physicians in these industries

who would be eligible for such service.

Public Health Services. Most health departments are already functioning on skeleton staffs and are unable to release additional physicians for military service. In fact, some health departments are so urgently in need of trained personnel, that the United States Public Health Service is supplying such personnel on a "lease-lend" basis.

Hospitals. The situation in the hospitals will become increasingly difficult. In order to conserve the time of physicians, there will be a tendency to hospitalize more patients. Medical school graduates who hold commissions in the Army and Navy will be granted a year, but only a year, of internship before being called to active duty. One result of this is that many of the large hospitals which previously had two-year internships are taking more first year interns in order to "cover" their services. This can only mean that some hospitals will have less interns than normally.

Hospital residencies will be continued, but the number of residents who can be deferred from military service will be very limited. Consequently, hospitals will find it necessary to depend, almost entirely, upon residents who are not acceptable for military service.

Critical Shortage Areas. It is estimated that approximately 6,000,000 people in this country have moved their homes as a result of the war. The provision of medical and health services to this group is one of the most important problems facing the medical profession and the Procurement and Assignment Service today. The principles and procedures for evaluating and meeting the needs of these groups were formulated in 1942, but most of the job still remains to be done.

The surveys which have been completed indicate that in many instances the urgent need is not for more physicians, or not only physicians, but rather for hospitals, nurses, or public health services. In a considerable number of areas the local medical societies in cooperation with public health departments and housing and welfare groups have been able to meet the needs for physicians either by having the doctors in the community or in neighboring communities give specific amounts of time to the shortage area or by inducing other physicians to move into the area. Reports from the states indicate that more than 900 physicians have taken positions in war industries or moved into "shortage areas" "during the past year and that approximately two-thirds of these moves have been the result of efforts of state or local Procurement and Assignment Chairmen or Committees. Similar methods doubtlessly can and will meet these needs in many other communities.

Some of the "boom town" communities, on the other hand, need considerable numbers of physicians as well as hospital beds, nurses, and other health services. Although the ratio of one doctor to 1500 population has been utilized by the Procurement and Assignment Service for planning purposes as the over-all number of physicians required to provide essential medical services to the civilian population, in shortage areas a ratio of one to 3,000 has been accepted as the coverage beyond which the situation would be considered critical.

The responsibility for formulating plans to meet these needs has been placed primarily upon the Procurement and Assignment Service and the state and local medical societies. Most of the residents of these areas are earning good incomes and should be able to support physicians on a private practice basis. If it is necessary in special situations to provide partial subsidy to a physician for a limited period of time to enable him to move into such an area and establish himself in practice, funds for such subsidy may be requested from the United States Public Health Service. In some areas pre-payment plans for medical services under the supervision of the state medical society are meeting the need. In rare instances it may be necessary to assign an officer of the United States Public Health Service to practice temporarily in the area. Such an assignment. however, will be made only as a last resort and upon the joint recommendation of the Procurement and Assignment Service Service and the United States Public Health Service.

In meeting these situations the medical profession is faced with a new responsibility. Medical societies have always been concerned with keeping their members abreast of new development and progress in medicine and with the maintenance of high standards of ethics and practice among their members. Never before have they had reason to feel responsibility for the availability or adequacy of medical care for the general population. The laws of supply and demand have largely taken care of that. Now, however, the war has given rise to a new problem of medical care which must be met. The physicians of this country are given the opportunity of meeting these needs in the way that one deems best. We sincerely hope and believe that they will be able to meet this challenge.

CONCLUSION

As the representative of the Directing Board of the Procurement and Assignment Service, I welcome the opportunity this occasion has provided to briefly summarize these major problems which confront

each and everyone of us in the medical profession in the critical times remaining before our country can emerge victorious in the titanic struggle in which we are engaged. In meeting such responsibilities, the medical profession has always done its full share, and we are confident that, come what may, the physicians of this country can be depended upon to do their share and more in meeting their problems and responsibilities.

HISTOPLASMOSIS

REPORT OF A CASE WITH BRIEF REVIEW OF THE LITERATURE

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Samuel T. Darling, M.D., pathologist for the Ancon Hospital, Ancon, Canal Zone, first described[1] histoplasmosis as a protozoan general infection producing pseudotubercles in the lungs and focal necroses in the liver, spleen, and lymph nodes. Darling's first case was published in 1906. In 1908 Darling reported two more cases[2] which he saw in the Canal Zone. No further cases were reported until 1926 when Watson and Riley reported[3] a case in Minnesota. From this time and especially in the last ten years, many new cases have been reported. At present, counting the case reported in this paper, there have been forty-three cases reported or mentioned in the literature.

Definition.—Histoplasmosis is a fatal, generalized, infectious, yeastlike, fungus disease which has a predilection for reticuloendothelial and epithelial cells. This disease is characterized by an irregular fever, enlargement of the spleen and liver, anemia and a persistent leucopenia.

Etiology.—Darling concluded from a laboratory study of his three cases that the causative organism of histoplasmosis was a protozoan similar to the Leishmann-Donovan body of Kala Azar but differing from this body in the form and arrangement of its chromatin nucleus and in not possessing a chromatin rod. He therefore proposed the name "histoplasma capsulatum" for this organism and at this time considered it to be a protozoan.

Da Rocha Lima[4], in 1912, examined the material from Darling's cases and concluded that the organism was not a protozoan but probably a fungus. cryptococcus farciminosis, the causative organism of epizootic lymphangitis in horses. Actually Da Rocha Lima considered the cryptococcus farciminosis of Rivolta (1873) to be a yeast and not a fungus. It seems that Rocha Lima has thus corrected two scientific errors. Da Rocha Lima's work has been studied by many investigators and his conclusions are generally supported. According to Meleney[9], Darling has concurred with Da Rocha Lima in his conclusions.

De Monbreun[5], using the agent isolated from Dodd and Tompkin's case, demonstrated in a series of classical experiments that the organism could be cultured and grown in two forms, i.e., a yeast-like form and a mycelial form. He produced the disease in monkeys and showed that the yeast-like form was pathogenic to man and was found most often intracellularly. De Monbreun concluded that "Although certain cultural characteristics of the organism are suggestive of those of the Endomycetales group of fungi, it seems best to retain for it the name histoplasma capsulatum as given by Darling, until comparative cultural studies determine its logical classification."

Ciferri and Redaelli are of the opinion that the organism "must be classified among the Blastosporelaes sensulati, or the group of budding yeasts."

One can readily see that confusion still exists as to the proper mycological classification of this organism, but this is of limited significance clinically. For the present, one is probably safe in calling this organism "histoplasma capsulatum" while considering it to be a yeast-like fungus.

From an examination of Chart I, one can readily see that an irregular fever was present in all cases reported except Meleney's, Hansemann-Schenkman's, and Phelps-Mallory's[10]. This chart indicates that an irregular fever was present in practically 100 per cent of the cases. In at least half of these cases with fever, the fever was accompanied by, or followed by chills.

Vomiting was present in nine of the thirty cases recorded in Chart I.

Diarrhea was present in seven of the thirty cases. The type of stool was inconstant; some stools were watery, others were bloody, while others showed a variable constituency.

Cough was present in thirteen of the thirty cases reported.

Loss of weight was present in twenty-nine of the thirty patients. The loss of weight in these patients varied from a few pounds in a few cases to extreme emaciation in many cases.

Practically all of these patients showed some degree of weakness.

PHYSICAL SIGNS

Upon examination of the section headed "signs" in Chart I, one notices that enlargement of the liver and of the spleen go hand in hand to a remarkable

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degree. The incidence of each is seventy-seven per cent and eighty per cent respectively. The only cases which failed to show simultaneous enlargements of the liver and spleen were Gunter-Lafferty's and Palmer-Amolsch-Shaffer's in which there was no enlargement of the liver, and Henderson-Pinkerton's in which there was no enlargement of the spleen.

Enlargement of the lymph nodes occurred in at least one part of the body in nineteen of the thirty cases. In many of these cases the adenopathy was not evident until autopsy. It follows that although adenopathy may be present in a high percentage of the cases, it frequently is not observed as a clinical sign.

It is evident from Chart I that enlargement of the spleen and of the liver are very important signs in the diagnosis of histoplasmosis. One should be reluctant to diagnose histoplasmosis in the absence of these signs.

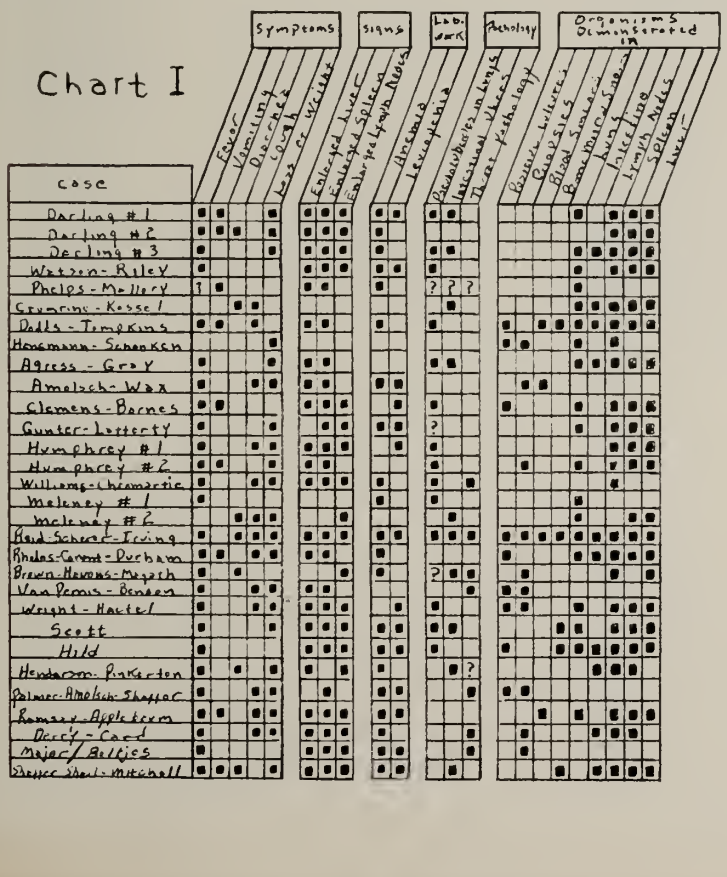
Anemia was present in twenty-three of the thirty-nine cases and leucopenia was present in fourteen of the thirty cases reported. In the patients in which either anemia or leucopenia occurred it occurred simultaneously in forty per cent. The anemia was secondary in type and varied from "low grade to "marked". The leucopenia was, as a rule, persistent. Secondary anemia and a persistent leucopenia are therefore to be considered as extremely important laboratory findings in the diagnosis of histoplasmosis.

PATHOLOGY

Darling's first paper which was entitled "A protozoan general infection producing pseudotubercles in the lungs and focal necroses in the liver, spleen and lymph nodes" gives us a good idea of the pathology found in the organs thus mentioned. In addition to the lesions thus mentioned, mucocutaneous lesions in the form of papules, scaly lesions, purpuric lesions and ulcers are occasionally seen.

"Throat Pathology" again is a very general term, including everything from a simple sore throat to active ulceration. It is mentioned because in seven of the thirty reported cases, some degree of throat pathology occurred. In not a few of these cases the throat pathology was of prime importance. It would be wise to consider the possibility of histoplasmosis when throat lesions are accompanied by any of the other signs or symptoms of the disease.

Henderson, Pinkerton and Moore pointed out in their publication[7] of March 14, 1942, that many of the cases reported in the literature had an ulcerative enteritis but few showed clinical evidence of this lesion. According to Chart I, ten of the thirty reported cases had varying degrees of ulcerative enteritis and of these ten patients, six complained of diarrhea. Diarrhea itself does not strongly suggest ulcerative enteritis but in a case which has any of the other signs or symptoms of histoplasmosis, diarrhea might recall to mind the possibility of an ulcerative process in the intestine.



MICROSCOPIC FINDINGS

Histoplasma capsulatum was demonstrated in biopsy material nine times in the thirty reported cases and four times in the eleven cases reported or mentioned** by Meleney. Biopsies were done in relatively few of these cases; the percentage demonstration of organisms in biopsies is quite high.

Organisms were demonstrated in blood smears four times and in bone marrow smears five times. These figures were taken from all cases which have been reported or mentioned in the literature and these laboratory procedures were carried out on relatively few cases. The antemortem demonstration of organisms in blood and bone smears is obviously the most important single diagnostic procedure.

**Meleney has reported two cases and has mentioned many other cases in his excellent review of histoplasmosis.

Of the autopsy material, organisms were demonstrated in seven adrenal glands, in material from twenty lungs, in material from twelve intestinal ulcers or nodules, in twenty-four lymph node sections, in twenty-three liver sections, and in twenty-one spleen sections. These results are taken from all of the cases reported or mentioned. These findings tend to show that the diagnosis of histoplasmosis should be easy for the pathologist.

Summary of the microscopic findings: Biopsies from gross lesions very frequently reveal histoplasma capsulatum. Blood and bone marrow smears will frequently permit a positive antemortem diagnosis. Sections from autopsy material show organisms in a remarkably high percentage of cases.

DIAGNOSIS

In going over the literature we note that many clinicians have said that histoplasmosis cannot be diagnosed except by finding the histoplasma capsulatum. To substantiate this belief, the literature shows that of the forty-three cases mentioned and published, diagnosis during life has been made relatively few times. It is true that a positive diagnosis can only be made when the organism can be demonstrated in the tissues.

The diagnosis of histoplasmosis should be considered if the patient shows irregular fever, some degree of weight loss or emaciation, an enlarged palpable spleen and liver, secondary anemia and a persistent leucopenia.

Intestinal ulcers and throat pathology may, at times, be demonstrated and these are valuable adjuncts in making the diagnosis.

The following examinations should be carried out on every patient suspected of having histoplasmosis: Microscopic study of stained blood and blood marrow smears, study of sections obtained by biopsy, attempts to isolate pure cultures of the histoplasma capsulatum from the lesions.

Blood smears and bone marrow smears may be stained with ordinary hematoxylineosin or with Goodpastures stain. The capsule of the organism usually shows a polymorphous chromatin nucleus with a cytoplasm which may be basophilic, or unstained, or it may just show scattered achromatic spaces. The organism measures from one to four microns in diameter.

The organism may be isolated and grown in pure culture on Sabouraud's medium. Reid, Scherer, Herbut and Irving were able to grow the organisms on their stock blood culture and on Sabourand's medium. The reader is referred to this paper[8] and to De Monbreun's paper[5] on the cultivation and cultural characteristics of this organism.

If organisms can be demonstrated by any of these procedures, the diagnosis of histoplasmosis is certain.

PROGNOSIS

Only one case of histoplasmosis with recovery is recorded, that of Mantell and Troy which is mentioned by Meleney. This patient was given Neostam and he made a clinical recovery after six months. At the end of six months the patient still had a slight enlargement of the spleen and liver. He also had a slight anemia with transient erythematosus. Although this is encouraging, adequate conclusions can hardly be drawn from one case. Histoplasmosis, with this one exception, has been 100 per cent fatal and at this time the prognosis is hopeless.

TREATMENT

The only treatment that has apparently been successful was that of Mantell and Troy wherein Neostam, a pentavalent antimony preparation was used. The patient recovered to the extent just described under "prognosis."

The following case, probably the first observed in Kansas, was studied twelve years ago but is now reported for the first time.

CASE REPORT

The patient, a white male, aged forty-two years, came in the University of Kansas Hospitals, December 30, 1931, complaining of sore throat, dysphagia, weakness, shortness of breath, swelling of the feet and ankles, frequency, and blindness of the right eye.

The onset of the present illness began three months before admission when the patient developed a sore throat. This throat condition became increasingly worse and one and a half months after the onset, the patient could scarcely swallow. The weakness and shortness of breath began quite suddenly six weeks after the onset of the sore throat. The swelling of the feet and ankles dated back four years and the frequency had been present many years. The patient had lost twenty pounds since the onset of the illness.

The personal history reveals that the patient had pneumonia twice as a child and rheumatic fever at twenty-two years.

Physical Examination: The patient is an undernourished white male appearing older than forty-two years. The mucous membrances are a good color; skin is dry; eyes show right external strabismus. There is a small hard indurated growth on the tongue, one cm in diameter. There are also smaller similar patches about two mm in diameter around this larger area and on the left pillar, on the posterior pharyngeal wall, and under the tongue on the left side.

Chest: Expansion shallow; breath sounds harsh. Heart: PMI in sixth interspace, one cm to the right

of the midclavicular line. Thrill felt at apex. Harsh systolic murmur at the apex not transmitted well. Heart is irregular in volume and in rhythm. B.P. 104/64.

Abdomen: Liver palpated four fingers below costal margin. Spleen is enlarged and easily palpable. Right undescended testicle. Right inguinal hernia.

Extremities: Pitting edema of both feet. Reflexes normal.

Laboratory findings: Urine, negative. Red blood cells 3,700,000, 3,900,000, hemoglobin seventy-one per cent and seventy-three per cent. White blood cells 4,000, 6,200 with fifty-two per cent polys, eight per cent monos, and thirty per cent lymphs. Blood Wasserman and Kahn were negative. Blood chemistry within normal limits. Smear from mouth negative for fungus. X-ray of the chest showed a heavy hilar shadow. Electrocardiogram showed auricular fibrillation.

Clinical Impression: Mitral stenosis with auricular fibrillation, right inguinal hernia, right undescended testicle, mycotic granuloma of the mouth and throat.

Course: The condition of the patient's throat improved at first but later had become progressively worse. He ran an irregular fever and became progressively weak and dyspneic. He died apparently a cardiac death on January 23, 1932.

On January 11, twelve days after admission, a biopsy specimen was removed from the tongue. The pathologist reported mycotic granuloma of the tongue, specific parasite not known.

Treatment: The treatment consisted of quinidine for the fibrillation and narcotics and stimulants at various times.

Autopsy findings: Gross: The tongue and esophagus showed some papilliferous, granulomatous lesions grossly and an ulcer was present in the pharynx. Both lungs were adherent to the posterior chest wall. On cut section, the right lung showed several dark red nodules about two centimeters in diameter. The hilar lymph nodes were enlarged. The heart showed typical findings of a mitral stenosis. The liver and spleen were both enlarged, the liver weighing 3,020 grams and the spleen weighing 1,100 grams. The kidneys, pancreas, gallbladder, prostate and thymus showed nothing unusual grossly. The adrenals showed some necrotic areas in the cortex.

Microscopic findings: The heart, lungs, liver, spleen, pancreas and kidney show nothing significant.

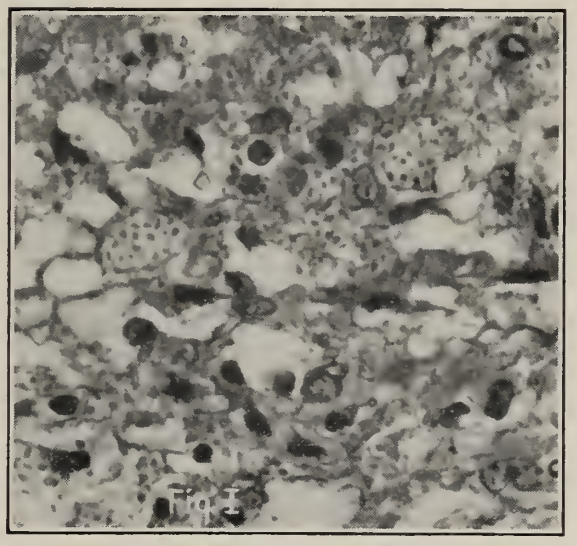
The adrenals show large areas of caseous necrosis. The tissue surrounding these necrotic areas is composed of cells which contain small round refractile bodies in which chromatin granules are present.

The ulcer from the pharynx upon section showed a surface covered with a thick layer of chronic inflammatory tissue in which mononuclear cells are seen. Giant cells are not seen. Throughout this tissue large phagocytic cells are seen which contain refractile bodies of varying sizes. These refractile bodies contain small brown granules and are both intra and extra-cellular.

COMMENT

Death was evidently due to a myocardial disease with acute dilatation which probably followed an old mitral stenosis. Terminal bronchopneumonia was probably an important factor.

A very interesting and unusual contributory lesion was also found; this lesion consisted of a granulomatus ulceration of the upper respiratory passages with an unusual type of bilateral granuloma of the adrenal gland. This gross picture suggested tuberculosis of the adrenals but there were no typical tubercles present. Under the microscope these granulomatous lesions of the adrenals showed an unusually large number of large pale vacuoles filled with rounded refractile bodies, containing central chromatin granules, characteristic of histoplasmosis. (Fig. 1.)



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(Continued on Page 234)

President's Page

To the Members of the Kansas Medical Society:

The administration of any new organization or plan carries with it many debatable details. There has arisen out of the Children's Bureau, the soldier-wife obstetrical care plan. This was originally placed in the hands of our Committee on Maternal Welfare and they approved the plan in general, realizing that there were some details that would cause unrest among the hospitals and physicians. It would seem to me that as a profession, we should cooperate with this plan and do everything in our power to render a fine service to these soldier's wives. Since the care and delivery of these wives must come under the direct supervision of a medical physician, it is our duty to render a good service that will be a credit to the profession. At times the hospitals will be crowded to capacity and you will be unable to keep the case in the hospital the recommended ten days. With tact, each physician can handle the situation, with explanation of the problem.

No doubt the change of policy, whereby narcotic permits have been removed from hospitals, will cause some inconvenience to the physicians. This entire problem was submitted to the Council and some twenty other physicians and they have already sent to you their recommendations as to procedure. I sincerely trust that you will consider all the various angles to this problem before you either refuse to cooperate or be critical of the plan evolved.

Sincerely,

J. L. Lattimore M.D.

President, The Kansas Medical Society

EDITORIAL

THE WAR EFFORT IN KANSAS

Due to the fore-sight and wise planning of the medical Preparedness committee of the American Medical Association and the remarkable contribution made by the members of the National Board of the Procurement and Assignment service for physicians, dentists and veterinarians, it has been possible to maintain the medical phase of the war effort on a volunteer basis. Few, if any of us, can fully appreciate the worthwhileness of such a program to our armed forces, the civilian population and our industrial and educational institutions. It is to be hoped that the volunteer method will continue to be the one of choice throughout this period of war emergency.

In Kansas, as elsewhere throughout our country, the performance of the men of medicine is a matter of record. Since December 7th, 1941, four hundred and seventy-six of our number have responded to the call to arms and are now giving their all to the war effort. They are scattered everywhere along the far-flung battle fields of the world. Speed the day when they can return to their homes, sound in mind and limb and rich in courage, better men and better physicians because of their experience.

It is with the greatest difficulty that those of us compelled by age or physical incapacity to remain at home are enabled to adopt a philosophy of life at all tolerant of home service when the entire world about us is a battle front. The importance of so-doing however cannot be over-emphasized. The temporary loss of the services of our men at the front does have a crippling effect upon our people and certainly it becomes the obligation of the eleven hundred physicians now serving on our home front to fill in the gaps, take up the slack and carry on. We must appreciate the significance of the long hard pull which lies ahead and be prepared to endure with a high degree of equanimity any privation which may occur incident to the winning of this war. If we have been held as unavailable for service with the armed forces, let us hold ourselves ever available, to accept assignments on the home front where we are most needed.

If we are called upon this year to give an additional number of physicians for service with the armed forces our relocation problem will become acute. We must anticipate such a problem and be prepared to meet it. We must develop a personal relationship to our war effort. Nothing else should concern us. We must not think of winning this war in terms of some-one else fighting our fight for us. Whenever a medical need exists in any community within a reasonable traveling distance from us, our responsibility as physicians should be exercised. If we fail to meet this obligation, our relocation problems may be troublesome. Many areas in our state are on the boom due to industrial development directly related to the war effort. With one exception these areas are located within or adjacent too our larger centers of population and should not present medical problems unduely critical.

We have much for which to be thankful. We have had the privilege of making known our capabilities to our government. We have had the rare privilege of being permitted to volunteer our services to our government and, lastly, those of us serving on the home front possess a God-given obligation to keep the fires burning on all the hills until we win this war.—Forrest L. Loveland, M.D.

SOCIETY COMMITTEES

Dr. John L. Lattimore, president, of Topeka, announces in this issue of the Journal his committee appointments for the year 1943-1944.

The Committee on Statute Research is a new committee this year and its object is to re-writing for possible revision the Kansas Medical Practice Act. The three committees created by Dr. Lattimore's predecessor, Dr. Henry Tihen, namely the Committee on Control of Appendicitis, the Committee on Conservation of Hearing and the Committee on Plasma will continue to function this year.

Two hundred and forty-eight members were appointed on the various committees. These men are located in all parts of the State. Every district, county society and section of Kansas is represented in so far as possible.

The Society committees for 1942-1943 faced many new an unforseen problems as will the committees now being appointed. The last year's Committee on Maternal and Child Welfare participated in the program for securing federal funds for the instigation of the maternal and infant care program for service men's dependents which was inaugurated in Kansas last month. The comparatively new Committee on War Work had an unusually large amount of work in the procurement and assignment of physicians and the re-location of other physicians throughout the state to insure civilian medical care in the war expanded industrial centers. The Committee on Scientific Work, whose duty it usually is to select the state meeting speakers and plan the program, has during the past year sponsored a post graduate course on tropical medicine which has met with initial success.

Society activity for any year depends in a large measure on the work of the various committees. Dr. Lattimore is to be congratulated on an admirable job in his selection of committee men.

KANSAS MILITARY

We list below the names of the four hundred seventy-six Kansas physicians at present serving in the United State Medical Corps. Some new names have been added since the publication of the first list in the December, 1942, issue of the Journal. Kansas medicine is proud of her men in the services of our country and this edition of the Journal is dedicated to them.

ALLEN COUNTY

Garlinghouse, Robert O.
Maxson, Theodore R.
Nevitt, James R.
Robinson, Leo D.
Schmaus, Lyle F.

ANDERSON COUNTY

Spencer, Harold F.
White, Ralph E.

ATCHISON COUNTY

Bosse, Frank K.
Brady, Charles S.
Byrne, Ralph
Fast, William S.
Jeffries, Robert C.
Morrison, Ira R.
Rigdon, Jonathan M.
Wallace, Wayne O.
Wulff, Edwin T.

BARBER COUNTY

Dougan, A. F.
Gacusana, Jose M.
Grigsby, Kenneth R.
Turner, Ralph D.

BARTON COUNTY

Carlson, Marlin W.
Dillon, John A., Jr.
Gaume, James G.
Kendall, Donald A.
Leiker, Raymond J.
Roesler, Bruce E.
Robinson, Corbin E.
Wenke, Leo L.

BOURBON COUNTY

Albright, Fred C.
Cooper, Lawrence L.
Cushing, Robert L.
Irby, Pratt
Irby, A. C.
Randles, Leland P.
Stone, Francis M., Jr.
Young, Robert S.

BROWN COUNTY

Hinton, Elmer E.
Wyatt, Ralph M.
Lawrence, Edward K.

BUTLER COUNTY

Brian, Robert M.
Cloyes, Arthur P.
Hyde, Marshall E.
Johnson, Joseph H.
Metcalf, Ralph J.
Murray, Leo. C.
Steffen, Lawrence F.

CHEROKEE COUNTY

Athy, Gregg B.
Bux, Donald E.
Martin, Oliver L.
Wolohon, Harry G.

CLAY COUNTY

Anderson, Severt A.
Garrett, Glen H.
Klauman, Benjamin F.
McIlvain, Guy B.
McVey, Roy B.

CLOUD COUNTY

Kiene, Richard H.
Kosar, Clarence D.
Porter, John M.
Robertson, Howard T.

COFFEY COUNTY

Hunter, Kenneth R.

COWLEY COUNTY

Brown, Harwin J.
Cummins, Walter J.
Grosjean, Wendell A.
Hall, Frederick W.
Moran, Charles T.
Norris, George L.
Snyder, Howard E.
Ward, Delbert A.
Weston, William G.

CRAWFORD COUNTY

Bell, Cleo D.
Bena, James H.
Erickson, Clarence W.
Evans, John Frank
Mollahan, Morgan L.
Newman, Clifford B.
Revell, Arthur J.
Schulte, Edward J.

Haigler, James P.
Haigler, Frederick H.
Veatch, Harry J.
Wood, Douglas H.

DICKINSON COUNTY

Conklin, Kenneth E.
Danielson, Arthur D.

DONIPHAN COUNTY

Mothershead, John L.
Swails, John G.

DOUGLAS COUNTY

Anderson, Arthur S.
Auchard, Virgil M.
Brooks, Dean
Dunlap, Richard L.
Enders, Edwin Wray
Hood, Thomas R.
Jones, Hiram P.
Mott, James M.
Nelson, Dick
Powell, Lyle S.
Renick, Fred T.
Schwegler, Raymond A.
Vetter, Ronald C.
Walters, Byron

EDWARDS COUNTY

Johnson, Charles H.

ELLIS COUNTY

Brewer, William M.
McDermott, Alza M.

ELLSWORTH COUNTY

Horejsi, Alfred J.

FINNEY COUNTY

Lewis, George Kenneth
Sartorius, Herman C.
Maxfield, Russell J.

FORD COUNTY

Alderson, Clair M.
Davis, Donald
Dennis, Foster L.
Mandeville, George
Speirs, Richard E.

FRANKLIN COUNTY

Badger, Edward B.
Barr, John F.
Davis, George W., Jr.
Wallen, James E.
Henning, Colvin W.
Henning, Joseph R.
Kaiser, Max E.

GEARY COUNTY

Brethour, Leslie J.
Carr, Robert M.
Filkin, Lawrence E.
Gold, David
Lanning, Robert J.
Smiley, Edward A.

GRAHAM COUNTY

Vesper, Vernon A.

GREELEY COUNTY

Wilson, Donald J.

GREENWOOD COUNTY

Baird, Cecil D.
Fairbrother, William C.
Basham, Charles E.

HARPER COUNTY

Pokorney, Charles

HARVEY COUNTY

Buehler, C. T.
Enns, Eugene K.
Gleason, Kenneth J.
Gradinger, Billens C.
Grove, John A.
Grove, William E.
Hawkey, Alfred S.
Hertzler, John W.
Kamish, Robert J.
Martin, Melvin C.
Miles, Paul W.
Munsell, D. W.
Oltman, T. V.
Poling, Fowler B.
Rhoades, Gordon
Rost, Glenn S.
Schmidt, C. Robert
Sills, Charles T.
Street, Glenn
Walsh, William S.

HONOR ROLL

JACKSON COUNTY

Condon, Albert Paul
Moser, Ernest C.
Wyatt, Charles A.

JEFFERSON COUNTY

Bowen, Clovis W.
Martin, Earl A.

JEWELL COUNTY

Turner, Robert C.

JOHNSON COUNTY

Becker, Richard R.
Beebe, Edmer
Carbaugh, Kenneth W.
Grayson, Roy David
McFarland, M. Donald
Muller, Samuel B.
Maser, George R.
Owen, Snyder E.
Reece, Adelbert S.
Tolle, Cecil E.
Weaver, James B.

KINGMAN COUNTY

Baldridge, Richard E.
Eggleston, Donald E.
McCarty, Dale C.
Knappenberger, Roy C.
Waylan, Thornton Lewis

KIOWA COUNTY

Wilson, William Errol

LABETTE COUNTY

Baird, Albert C.
Carter, Percy C.
Cramer, Guy W.
Donnelly, Bernard A.
Rose, Ralph J.
Wilson, D. R.

LEAVENWORTH COUNTY

Epstein, Joseph G.
Gier, Jacob B.
Gonser, Karl B.
McKee, Richard S.
Moore, Robert H.
Sereres, Edgar P.
Thomas, William M.
Voorhees, Gordon S.
Watkins, Lucien A.

LINCOLN COUNTY

Andreson, Paul S.
Kerr, Richard Keith
Songer, Herbert Lee

LINN COUNTY

Lee, Carleton H.

LYON COUNTY

Butcher, Thos P.
Byrnum, Frank L.
Davis, David R.
Eckdall, Funston J.
Foncannon, Frank
Harvey, Clarence C.
Kerr, Samuel E.
Morgan, David
Morgan, John L.
Neinstedt, John F.
Underwood, Charles C.

MC PHERSON COUNTY

Lewis, Letteer
Price V. C.
Sohlberg, Robert Jr.
Stensaas, Carl O.

MARION COUNTY

Siebert, Norman C.
Thomas, Theodore J.
Unruh, Rudolph T.

MARSHALL COUNTY

Bolton, Dan W.
Diefendorf, D. M.
Lafene, Benjamin Wm.

MEADE COUNTY

Wakeman, Everal M.

MIAMI COUNTY

Aldis, John
Brown, William
Fowler, James T.
Keeton, Elvin E.*
Roach, Harry M.
Robb, T. P.
Speer, Louis N.

MITCHELL COUNTY

Bennet, Richmond E.
Jordon, Ralph E.

MORRIS COUNTY

Melchert, H. B.

MONTGOMERY COUNTY

Craig, Paul E.
Ellis, Stephen S.

NEMAHA COUNTY

Brown, Virgil E.
Rucker, Martin J.

NEOSHO COUNTY

Ashley, George L.
Cone, Luther H.
Edwards, James F.

NORTON COUNTY

Evans, Arthur W.
Petterson, Cecil E.
Stone, William F., Jr.

OSAGE COUNTY

Lyter, Clinton S.
McClintock, Edward A.

OSBORNE COUNTY

Gants, R. T.

OTTAWA COUNTY

Foutz, Homer S.

PAWNEE COUNTY

Coughlin, Samuel T.
Davis, Paul E.
Hyde, Marshall E.

PRATT COUNTY

Christmann, Marshall E.
Haworth, Kenneth W.
Reed, Joe G.
Thorpe, Francis A.

RENO COUNTY

Armitage, Albert C.
Barnes, Harold R.
Blank, John N.
Franklin, Glenn C.
Fernie, Robert W.
Hill, James N.
Ladd, Arthur C.
Pinsker, Jacob A.
Scales, William M.
Simpson, Ronald A.
Stone, Gordon E.

REPUBLIC COUNTY

Splichal, William F.

RICE COUNTY

Beauchamp, Preston E.
Bula, Ralph E.
Hill, Edwin R.
Marr, J. T.
Patterson, Harold L.
Sprong, A. A.

RILEY COUNTY

Ball, Ralph G.
Balding, Laurence G.
Evans, Darrel Lee
Hauckenberry, Everett
Horton, Robert John M.
Hughes, Raymond H.
Kempthorne, Charles R.
Marker, Daniel I.
Schwartz, Willard C.
Woods, Walton C.

RUSH COUNTY

Baker, Joseph H.

SALINE COUNTY

Anderson, Donald A.
Armstrong, Carroll W.
Cheney, Ralph E.
Druet, K. L.
Eaton, Leslie F.
Harvey, Ernest E.
Hatton, L. W.
Mitchell, John C.
Rueb, A. E.
Simpson, James C.
Snyder, Maurice
Stafford, George E.

SEDGWICK COUNTY

Adams, Austin J.
Anderson, Harry O.
Bartlett, Wayne C.
Blacker, Morris R.
Clapp, Raymond C., Jr.
Coffman, Delphos Otto
Donnell, Louis A.
Drake, Ralph L.
Magee, Charles R.
Matassarin, Frederick W.
Mermis, William Leo
Miller, Clyde W.
Mills, Earl L.
Needles, Orval Thomas
O'Donnell, Harold F.
Palmer, Harold W.

* Killed in service.

SEDGWICK COUNTY—*Continued*

Epp, Frederick O.
Fisher, James B.
Forman, Louis H.
Frey, Charles T.
Gsell, George F.
Hall, Millard W.
Hamilton, Oscar A., Jr.
Hibbard, James S.
Herbst, Robert Rudolph
Howard, Donald O.
Hurst, Thomas C.
Hyndman, Henry Harold
Kaufman, LeRoy V.
Kiser, Willard J.
Knapp, Leslie E.
MacLeod, Sherburn
Prochazka, Otto F.
Putnam, Lyle B.
Reed, Darwin C.
Reed, H. L.
Reitz, Harvey E.
Rhoades, Gordon H.
Ross, Earl B.
Stratemeier, Edward H.
Stout, Samuel L.
Scuka, Clayton L.
Thorpe, George L.
Warfield, Chester H.
Wier, Charles K.
Williams, Harold O.
Woodhouse, C. L.
Young, Paul B.

SEWARD COUNTY

Zimmermann, Leon W.

SHAWNEE COUNTY

Anderson, Robert C.
Ashley, Byron J.
Beller, Willis L.
Beach, George C., Jr.
Blake, Henry S.
Bowen, James D.
Bowen, Harry J., Jr.
Boyd, Spencer H.
Catlin, Karl A.
Clark, Orville R.
Crank, Henry Harlan
Eckles, Lucius E.
Finney, Guy A.
Ford, Frederick L.
Funk, Edward D.
Gale, Norman A.
Gorman, R. B.
Graber, Harold L.
Gray, David E.
Greenwood, Edward D.
Hammel, Seth A.
Helwig, George F.
Hunter, J. Theron
Joss, Charles
Kirkpatrick, Hazen L.
Krehbiel, B. I.
Menninger, William C.
Powers, Harold W.
Pusitz, Manuel E.
Pyle, Lucien R.
Raines, Omer M.
Riedel, Robert H.
Robbins, Louis L.
Saylor, Leslie L.
Saxe, Earl
Sellards, Howard E.
Schwartz, Lloyd E.
Scott, William B.
Stone, Mark L.
Swan, Otis Dwight
Taggart, Floyd C.
Tillman, Carl D.
Wakeman, Don C.
Zagaria, James F.

SMITH COUNTY

Sekavec, Gordon B.

STAFFORD COUNTY

Fritzmeier, William
Graves, Louis G.

SUMNER COUNTY

Buooa, Fern W.
Cole, Ward M.
Dewey, Charles H.
Evans, Ferris D.
Hill, J. E.
Howell, J. Allen
VanDeventer, Roy W.
Voldeng, Karl E.

TREGO COUNTY

Long, Gerald A.

WAUBAUNSEE COUNTY

Walker, William H.

WASHINGTON CONTY

Eckart, DeMerle E.
Knauff, Harry C.
McConchie, James E.

WILSON COUNTY

Beal, Lynn E.
Beal, Raymond J.
Meisburger, Richard G.
Moorehead, Frank A.
Rich, William T.
Stotts, Charles S.

WOODSON COUNTY

Lee, George R.

WYANDOTTE COUNTY

Abrams, William W.
Algie, William H.
Allen, Max S.
Angle, Lewis W.
Barry, William B.
Belot, Monte L., Jr.
Bernreiter, Michael
Betz, John S.
Bowser, John F.
Campbell, James W.
Carmichael, F. A., Jr.
Cziraky, Anton
Davis, C. G.
Davis, G. W., Jr.
Delp, Mahlon H.
Dillon, Tony G.
Ellis, Ralph Carlisle
Etzenhauser, Merrill H.
Evans, Joseph G.
Floersch, Hubert M.
Goldblatt, Bernard
Grosdidier, Edward J.
Gripky, Clarence
Hamilton, Tom Reid
Harless, Marris S.
Henry, Schubert David
Hiebert, Peter E.
Hinshaw, Alfred H.
Hinton, Elmer E.
Holter, Harold V.
Knight, Durell, K.
Lalich, Joseph J.
Laing, Maurice V.
Lee, Robert L.
Leger, Lee H.
Luke, John H.
McKean, Willis H.
May, James W.
Mellott, L. B.
Mullen, Clifford J.
Neas, Ingall H.
Phillips, Frederick N.
Neighbor, Ernest G.
Newman, Robert L.
Nothnagel, Arnold F.
Ortman, Garth S.
Rabe, Melvin A.
Reed, H. Lester
Reeves, Eugene A.
Richardson, Lyman K.
Richeson, Rae Arthur
Rieke, Frank A.
Rook, Lee Emerson
Rummold, M. J.
Ryan, Maurice J.
Ryan, Michael J.
Samuelson, Edward A.
Schiffmacher, Jack E.
Schulte, Emmerich
Shanklin, John H.
Sims, Thomas J., Jr.
Sophian, Abraham, Jr.
Speer, Frederick A.
Speer, Leland N.
Stauffer, Maurice H.
Steinzeig, Alfred S.
Stiles, Raymond C.
Turner, Robert C.
Walker, Maurice A.
Weber, Clarence J.
Wilson, Robert B.
Young, Chester Lee

HISTOPLASMOSIS

(Continued from Page 229)

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In pools of a sufficient number of samples of plasma or serum obtained from donors belonging to all four blood groups the amount of substances, known as anti A and anti B agglutinins, which might cause serious reactions is reduced to such a low level that no danger can result to patients from injection into a vein of even large therapeutic (treatment) doses from such pools, William Thalhimer, M.D., New York, declares in The Journal of the American Medical Association for December 19. His statement is based on his own investigations as well as an analysis of data of other investigators and is in answer to several recently published opinions questioning such a procedure on the basis of the possible danger from the injection or incompatible agglutinins or incompatible A or B substances.

NEWS NOTES

NEW COMMITTEES

Dr. John L. Lattimore, president of Topeka, has announced the following new Society committees to serve for the year 1943-1944:

ALLIED GROUPS

George E. Milbank, M.D., Chairman....Wichita
L. L. Bresette, M.D....Kansas City
O. R. Brittain, M.D....Salina
B. L. Greever, M.D....Hutchinson
C. A. Hellwig, M.D....Wichita
W. E. Janes, M.D....Eureka
R. R. Melton, M.D....Marion

APPENDICITIS

V. E. Chesky, M.D., Chairman....Halstead
L. C. Edmonds, M.D....Horton
L. E. Haughey, M.D....Concordia
J. G. Hughbanks, M.D....Independence
N. E. Melencamp, M.D....Dodge City
Samuel Murdock, M.D....Sabetha
F. H. Relihan, M.D....Smith Center

AUTOMOBILE ACCIDENTS AND FRACTURES

H. M. Glover, M.D., Chairman....Newton
G. R. Combs, M.D....Leavenworth
W. C. Heaston, M.D....McPherson
A. L. Hilbig, M.D....Liberal
L L. Williams, M.D....El Dorado

AUXILIARY

C Omer West, M.D., Chairman....Kansas City
W. Y. Herrick, M.D....Wakeeney
E. J. Nodurfth, M.D....Wichita
W. L. Pratt, M.D....Leavenworth
R. W. Urie, M.D....Parsons
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CHILD WELFARE

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MATERNAL AND INFANT CARE

The new maternal and infant aid plan for service men's dependents is meeting with huge success according to Dr. Fred Mayes, Director of the Division of Child Hygiene of the Kansas State Board of Health. In the first ten days after the Kansas program was instituted three hundred applications had been received in the Topeka office.

A similar plan is in effect in twenty-five other states and one territory at the present time. Additional information on the Kansas plan was published in the June issue of the Journal.

On July 3,745 applications had been received in Kansas and of these 700 had been authorized for acceptance. Eighty hospitals in the state are participating and 215 doctors of medicine. When the work is further advanced it is expected that many more doctors and hospitals will participate in the work. Information and blanks for the plan may be secured by writing to Dr. Mayes, Division of Child Hygiene of the Kansas State Board of Health at Topeka.

POST GRADUATE COURSE IN TROPICAL MEDICINE

The post graduate courses in tropical medicine sponsored by the Kansas State Board of Health, the University of Kansas School of Medicine and the Kansas Medical Society which were held in Emporia on May 22-23, in Wichita on May 29-30, in Salina on June 12-13, in Parsons on June 20-21, in Kansas City on July 10-11, will close with a meeting in Hays on July 24-25. Approximately fifty physicians have completed each of the courses and the program has met with unusual success.

The following speakers conducted the work: Dr. Paul B. Lawson of the Department of Entomology and Miss Mary

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E. Larson of the Department of Zoology, both of the Universcity of Kansas at Lawrence and Dr. H. L. Douglas of the University of Kansas School of Medicine at Kansas City.

The Extension Division of the University of Kansas had charge of the arrangements and registration at all meetings which was under the supervision of Mr. Harold Ingham of Lawrence.

NARCOTICS IN HOSPITALS

In regard to a decision in the situation of narcotics for hospital use, Dr. F. L. Lattimore president called a special meeting in Salina on June 27 of the councilors, officers and representatives of the various areas of the state. Others attending were Mr. Andres the President of the Kansas Hospital Association and Mr. Joseph Bell of the federal Narcotic Bureau.

Additional information on the narcotic situation will be published in the August issue of the Journal.

JOINT MEETING

The Golden Belt Medical Society with the Riley County Medical Society as host held a joint meeting with the Kansas Obstetrical and Gynecological Society in Manhattan on July 1.

The program consisted of the following: Dr. Fred Mayes Director of the Division of Maternal and Child Health of the Kansas State Board of Health gave an explanation of the federal plan for care of enlisted men's maternal and infant dependents; Dr. Porter Brown of Salina spoke on "Caudal Anesthesia in Obstetrics and Surgery"; Dr. L. A. Calkins of the University of Kansas School of Medicine of Kansas City spoke on "The Physiology of Labor" and Dr. Ray A. West of Wichita discussed the federal aid program in the state.

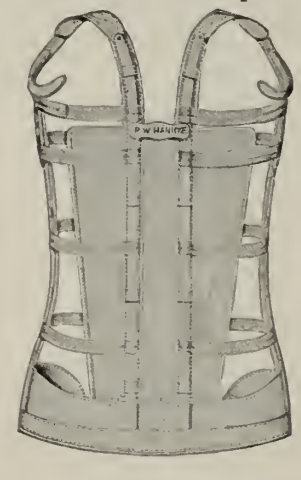
JOURNAL DESK

This is the month that the mailing list is completely checked and revised and the names of those members not having paid their 1943 dues are removed from the Journal list. Members in military service will receive their Journals if we are advised of their correct military address.

Several Journals have been returned in the past month and we have been advised of a new post office ruling on foreign second class matter as follows: "Individual copies of newspapers or magazines shall be accepted for dispatch to A.P.O.'s outside the continental United States only where subscriptions are specifically requested in writing by the addressee or for which subscriptions are now in effect. Such copies to individuals shall be accepted only from publishers who shall place on the wrapper, or on the publication when wrapper is not used, a certificate (which shall be regarded as sufficient to authorize their acceptance) reading as follows: 'Mailed in Conformity with P.O.D. No. 19687.'"

Believing that many of our members can save us a great deal of trouble, we would greatly appreciate having you send us the possible date of your transfer and the exact new address, which it is necessary to have in all second class matter, such as the Journal. We are most anxious that you receive your Journal, often it is the only bond with the Society and other members. Many of the Journals are re-

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Some of the Journal mailing changes made in the past month are as follows:

Dr. W. H. Tyler of Manhattan, is at the University of Iowa Hospital at Iowa City.

Dr. C. H. Lee, has been transferred from Talahasee, Florida, to Baton Rouge, Louisiana.

Major Clifford J. Mullen of Kansas City, is at Spokane, Washington.

Lt. Comdr. J. S. Hibbard of Wichita, has a Fleet Post Office address out of San Francisco, California.

Dr. Herbert Hesser, has advised the Journal office that he is leaving Milwaukee, Wisconsin, and will be located in Kansas City after July 1.

Dr. J. B. Ungles of Dodge City, is located in Satanta.

Dr. W. A. Parrish, formerly of Mulberry, is located in Pittsburg.

Dr. Caroline Juergens, formerly of Larned, is on the staff of the State Hospital at Topeka.

Dr. C. L. Ramsey, formerly in Nortonville, is in Atchison.

Dr. F. C. Tyree, has moved from Wayne to Agenda.

Lt. G. L. Norris of Winfield, is stationed at Balboa Island, California.

Major M. W. Hall, who was formerly stationed in Pasadena, California, has been transferred to Ozark, Alabama.

Lt. William Spencer Fast of Atchison, is stationed in Atlanta, Georgia.

Captain Robert Sohlberg, Jr. of McPherson, is in the San Antonio Aviation Center at San Antonio, Texas.

Dr. Raymond J. Ditterick, has moved from Fort Scott to Parsons.

Major T. V. Oltman of Newton, is stationed at Camp White, Oregon.

Dr. Hunter Duvall of Hutchinson, is in Berkley, California.

Lt. G. E. Stafford of Salina, is in Lincoln, Nebraska.

Dr. C. H. Johnson, has been transferred from Clearwater, Florida, to Randolph Field, Texas.

Lt. Frederick L. Ford of Topeka, has been transferred from Fresno to Los Angeles, California.

COMMISSIONS TO WOMEN DOCTORS

The Sparkman Bill, signed by President Roosevelt on April 17, permits women physicians to become eligible for commissions in the medical corps of the United States Army and Navy.

The Procurement and Assignment Service of the War Manpower Commission recently requested information on women physicians throughout the country. Once commissioned the women physicians will be entitled to the same ranks and privileges as men in the medical corps. Women physicians have for some time held positions in the United States Public Health Service.

NEW DOCTORS OF MEDICINE

The Kansas State Board of Medical Registration and Examination held an examination in Kansas City, Kansas, on May 19-20, 1943, and at the meeting of the Board in Topeka, June 17, 1943, it announced that certificates to

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The next examination will be held in Topeka at the Kansas Hotel on December 14-15, 1943. Dr. Mirl C. Ruble was re-elected president for the ensuing year. Governor Andrew F. Schoeppel has appointed two new members to the Board, Dr. J. D. Colt, Jr. of Manhattan, to succeed Dr. R. G. Ball of Manhattan, who is in military service and Dr. C. W. Jones of Olathe, to succeed Dr. J. E. Henshall of Osborne. Dr. J. F. Hassig, Kansas City, was reappointed for a term of four years. Other members of the Board are: Dr. H. E. Haskins, Kingman; Dr. C. E. Joss, Topeka, and Dr. O. L. Cox, Iola.

ANNOUNCEMENTS

The American Congress of Physical Therapy will hold its twenty-second annual scientific and clinical session on September 8-11 at the Palmer House in Chicago, Illinois, according to word received from Dr. Walter J. Zeiter the executive director.

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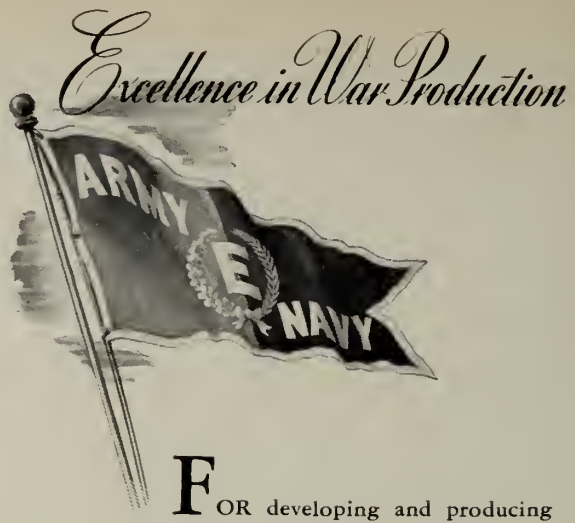
BOOK NOOK

BOOKS RECEIVED

A GUIDE TO PRACTICAL NUTRITION—Reprinted from Philadelphia Medicine, 1941-1942, with an introduction by Morris Fishbein, M.D., Editor of the Journal of the American Medical Association. The booklet of ninety-eight pages contains articles on the following subjects: Protein Requirements and Deficiency Diseases, Carbohydrates, Fat Metabolism, Minerals in Human Nutrition, Diets, Nutrition in Childhood and in Older Individuals, Vitamin Deficiency, the Vitamin B Complex, Riboflavin, Nutrition in Dental Disease and Nutrition as a Problem of War and Public Health. An interesting publication and well made up.

CHEMOTHERAPY OF GONOCOCCIC INFECTIONS —Russell D. Herrold, B.S., M.D., Associate Professor of Surgery (Urology) College of Medicine of the University of Illinois of Chicago, Illinois. Published by the C. V. Mosby Company of St. Louis, Missouri. The book is priced at $3.00.

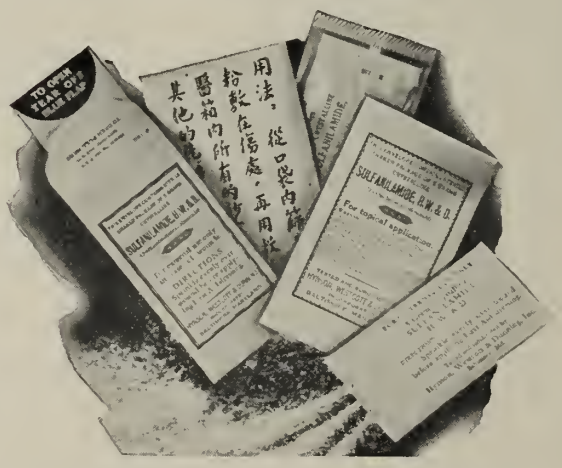
DISEASES OF THE SKIN—Oliver S. Ormsby, M.D., Rush Professor of Dermatology, of the University of Illinois; Attending Dermatologist to the Presbyterian Hospital of Chicago; Member of the American Dermatological Association and the American Academy of Dermatology and Syphilology; Corresponding Member of the Section of Dermatology of the Royal Society of Medicine of London, of the Societe Francaise de Dermatologie et de Syphiligraphie of Paris; of the Dansk Dermatologisk Selskab of Copenhagen; Honorary Member of the Wiener Dermatologische Gesellschaft of Vienna; of the Japanese Dermatological Society of Tokio; of the Greek Union of Dermatology and Venereology; of the Hellenic Antivenereal Society of Athens and of the Associacion Argentina de Dermatologia y Siflologia of Buenos Aires, and Hamilton Montgomery, M.D., M.S., Associate Professor of Dermatology and Syphilology the Mayo Foundation for Medical Education and Research, of the Graduate School, University of Minnesota of Rochester, Minnesota; Associate in Section on Dermatology and Syphilology of the Mayo Clinic; Member of the American Dermatological Association; American Academy of Dermatology and Syphilology; Society for Investigative Dermatology; Corresponding Member of the Societas Dermatologica Hungarica of Budapest; of the Asociacion Argentina de Dermatologia y Siflologia of Buenos Aires; of the Societe Francaise de Dermatologie et de



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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592*

Syphiligraphie of Paris. Published by the Lea and Febiger Company of Philadelphia, this sixth edition, revised, contains 1360 pages and 723 illustrations, and is priced at $14.00.

THE SIGHT SAVER—C. J. Gerling. Published by the Harvest House Company of New York, 50 West 17th Street. The book contains 202 pages and is priced at $2.00.

MEDICAL ASSISTANTS' HONOR ROLL

The following members of the Kansas Medical Assistants Society are now serving in the various branches of the armed forces and in the American Red Cross:

Nina Wisler, Red Cross.....Wichita
Dorothy Wyatt, Army Nurse.....Kansas City
Marie Schwartz, Navy Nurse.....Great Bend
Pearl Scott, W.A.A.C.....Kansas City
Christine Silady, W.A.V.E.S.....Kansas City

KANSAS MEDICAL ASSISTANTS SOCIETY

The Sedgwick County Medical Assistants Society held a meeting at the Allis Hotel in Wichita on June 16. Reverend J. C. Heinrich, Chaplain for the Council of Churches for the Defense Housing Areas of Wichita was the speaker, and having spent twenty-six years in India as a missionary gave an interesting talk on "Rural Projects in India". The Society voted to contribute $25.00 to furnishing a day-room in the Winter General Hospital at Topeka, which money was forwarded to the State Society to be added to the amount already collected.

A meeting of the Sedgwick County Medical Assistants Society was held at Wichita on May 19, with Miss Nina Wisler, president, presiding. The following new officers were elected for 1944 to take office on January 1: Zura Crockett as president; Helen Hall as vice-president; Martha Heitz as secretary; and Opal Kaminke as treasurer. Margaret Parrott gave her delegates report of the state convention held on May 16 in Topeka. Nina Wisler tendered her resignation as president and announced that on June 1 she was reporting for duty as an Army Red Cross Nurse. She was presented with a leather writing portfolio by the members of the society.

The June 7 meeting of the Shawnee County Medical Assistants Society was held at Topeka and the following were elected to office for the new year: Kathleen Futter as president; Marjorie Euler as prsident-elect; Grace Brooks as vice-president; Alice Dangerfield as secretary, Myrtle Coats as treasurer; and May Evans, Alma Anstrom and Blenda Blankenship as members of the board of directors.



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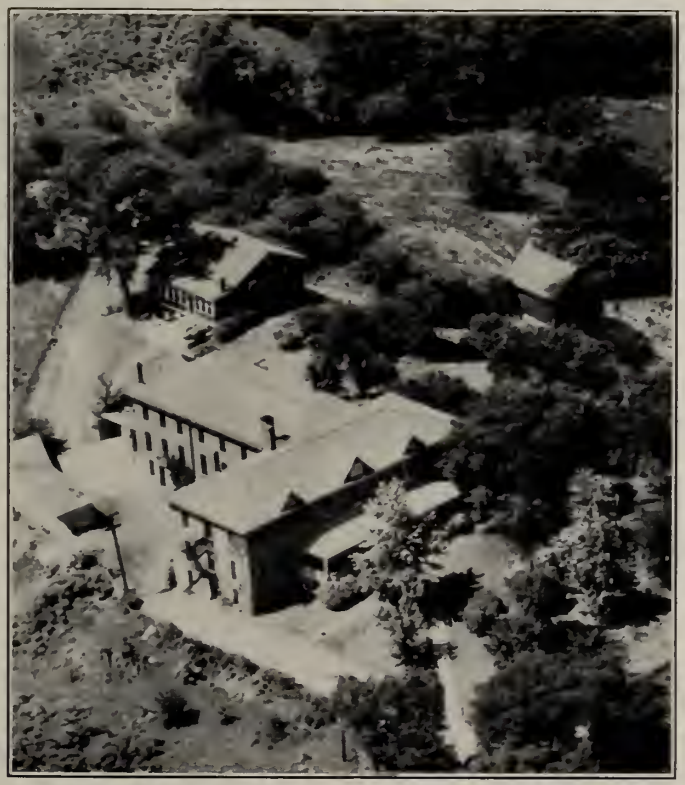
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MRS. H. L. REGIER, Kansas City, Kansas.....Secretary
MRS. E. N. ROBERTSON, Concordia.....Treasurer

PRESIDENT'S MESSAGE

The twenty-first national convention of the Woman's Auxiliary to the Medical Association was held at the Drake Hotel in Chicago, June 7-9. It was an inspiring meeting even if transportation made it impossible for some of the states to be represented. The Kansas State Auxiliary had two delegates besides your president. They were Mrs. Hugh Hope of Hunter and Mrs. William F. Abramson of Topeka. It was terribly cold in Chicago for June and the Chicago women were wearing fur coats. Our spring coats seemed pretty thin.

The theme "Coming of Age" was carried throughout the meetings. Very much in evidence were the delegates from Atlanta, Georgia in their blue uniforms. They have named themselves "Doctor's Aids". The postboard Bulletin will tell more of their organization. Also in the Bulletin will be plans for the coming year's work.

The new president, Mrs. Eben J. Carey of Wauwatosa, Wisconsin is a native of Kansas. Although she moved away when young she is very much interested in Kansas.

Today we canned beans from our victory garden, pulled weeds, worked over the garden, and took the horse out to the farm for tomorrow we are going to Colorado to spend a short time at our cabin near Woodland Park.

Sincerely yours,
Mrs. E. E. Tippin.

DAY NURSERIES FOR DEFENSE WORKERS

The Office of Civilian Defense of Washington, D. C., recently released the announcement that civilian defense classes throughout the country have trained 38,676 women to care for war workers' children in day nurseries.

The report released was based on figures received from 745 local defense councils. However, 300 council offices have not as yet reported.

Careful pasteurization of all dairy products is an essential safeguard against milk borne brucellosis (Malta or undulant fever), it is pointed out in The Journal of the American Medical Association for January 30 in a report on a milk borne epidemic of the disease in Marcus, Iowa. The report is presented by I. H. Borts, M.D., Iowa City; D. M. Harris, M.D., Le Mars, M. F. Yoynt, M.D., Marcis; J. R. Jennings, B.A., and Carl F. Jordan, M.D., Des Moines.

From their findings the investigators also advise that hogs should not be permitted to run on the same lot with dairy cows and that prevention of the occurrence of brucellosis in human being requires a continuing program and effective measure for the eradication of the disease among farm animals. The epidemic at Marcus, involving seventy-seven persons, was caused by a strain of the organism causing brucellosis which was traced to a raw milk supply. It was found that hogs had been allowed to mingle freely in the same pasture with the dairy cows.

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CLASSIFIED ADVERTISEMENTS

FOR SALE OR RENT—Equipped office, four-room building, for general practice in town of 1,400, south-central Kansas, for sale or rent. Write for details to T. J. Thomas, M.D., Veterans Administration Hospital, Waco, Texas.

FOR SALE—Entire ultra-modern medical equipment of the late Dr. Harrison B. Talbot for sale—Address Journal of The Kansas Medical Society, C-03. Mrs. H. B. Talbot, 600 West Eleventh Street, Apt. No. 6, Topeka, Kansas.

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FOR SALE—Entire office equipment, including instruments and files, of Eye Ear, Nose and Throat Specialist. Collections last year over $10,000. Growing town of 20,000. Write Journal of The Kansas Medical Society C-0-4.

The Journal Of
THE KANSAS MEDICAL SOCIETY
Owned and Published by The Kansas Medical Society

Volume XLIV AUGUST, 1943 Number 8

AN UNUSUAL FRACTURE OF SECOND CERVICAL VERTEBRA

H. L. Collins, M.D.

Beloit, Kansas

A non-fatal fracture or dislocation of the upper two cervical vertebra, although not extremely rare, is sufficiently so to make the following case of interest.

CASE REPORT

Mrs. Wm. G., aged forty-two years, was admitted to the Beloit Community Hospital on August 13, 1940. Four weeks before, while traveling with her family in Utah, their automobile was involved in a head-on collision. She became unconscious immediately and was transported to a nearby hospital. There were deep lacerations of forehead, mouth, and chin. Several of her teeth were crushed, and her nose was broken. Shock treatment was given and lacerations were sutured. After some time, she became "semiconscious." An anteroposterior roentgenogram was then taken. It revealed a "fractured transverse process of a cervical vertebra." Her condition did not change for about two weeks. A DePuy neck brace was applied and she immediately improved. Two weeks later she arrived here with the neck brace very loose and her head poorly supported.

Physical Examination. A well developed woman, not acutely ill. Head and face revealed several healed lacerations. Eyes and ears were normal. Nose was deformed from a recent fracture. Several teeth were missing and portions of central incisors were broken off. The position of the head seemed too far forward and movements of extension, and rotation were greatly limited. There was a prominence in the neck in the region of the third cervical vertebra. Although movements were normal and reflexes were active, there was moderate, generalized muscle weakness of the entire left arm. Aside from multiple contusions and healed abrasions, there were no other abnormalities.

Both anteroposterior and lateral roetgenograms were taken. When the unusual deformity was seen, traction by means of a head halter was immediately applied and the films mailed to Dr. C. B. Francisco of Kansas City, Missouri, for consultation. A portion of his report follows:

"I must say that they are the most remarkable x-rays that I have ever seen of the cervical spine. Apparently the second cervical has been dislocated forward and displaced down so that it lies exactly in front of the third cervical body. How the cord escaped injury is a mystery."

I also showed these plates to our radiologist, Dr. Tice, at the University of Kansas Hospital.

Dr. G. M. Tice, "It looks as if the bony structures were sheared from the body evidently anterior to the cord leaving the cord intact. I have never seen one like it."

After one month of continuous traction, there was x-ray evidence of considerable callus formation. Muscle weakness in the left arm had greatly diminished, and the patient's general condition was very good. Ten days later her neck brace was re-applied, and in two weeks she was dismissed from the hospital. Frequent x-rays showed increasing density of the callus with no change in the deformity. A year later the brace was removed. This was with some difficulty as she was afraid to do without it.

At the present time, the patient is carrying on her usual household duties. The only abnormal physical finding is a moderate decrease in rotation and extension of her head. There are no neurological symptoms or findings.

DISCUSSION

Until the past fifteen or twenty years, it was commonly believed that fractures and dislocations of the atlas and axis were inevitably fatal. Since the more frequent use of x-rays, knowledge of these lesions has greatly increased. We know that many cases show very little clinical evidence of injury while others have the typical "broken neck" signs and symptoms. According to Clark,[1] fractures of the cervical spine constitute about 0.5 per cent of the total fractures of a large group of accidents, and approximately eighty per cent of these are in men. Dislocation is noted in twenty-two per cent of the fractures. Key and Conwell[2] state that because of

the location of the atlas and axis, they have considerably higher mortality than similiar injuries in the lower cervical vertebra.

This case demonstrates the standard need of both lateral and anteroposterior roentgenograms. She had no idea that her condition was of a serious nature. When the neck brace was applied, she immediately improved. Even then the diagnosis of "fractured transverse process" was not changed.

Interesting too is the fact that by conservative traction, the fractures were partially disimpacted or reduced, and that her symptoms were relieved. Eastwood[3] states that a certain amount of deformity causes no harm; the end results of all these injuries, whatever the positions of the fragments, is bony fusion between the bodies of the vertebrae, and some displacement causes no harm either in appearance or in function provided there are no nerve-root or cord symptoms. Schwart and Wigton[4] stress that a long latent period between the original accident and the onset of the neurological symptoms is possible.

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3. Eastwood, W. J.: Fractures and Dislocations of the Cervical Vertebra. Proceedings of the Royal Society of Medicine 33:651, August, 1940.
4. Schwarz, Gabriel A., and Wigton, Robert S.: Fracture-Dislocations in the Region of the Atlas and Axis with Consideration of the Delayed Neurological Manifestations and some Roentgenographic Features, Radiology 28:601, May, 1937.

Supply of Physicians May Not Keep Up With Demand—National defense demands for physicians may exceed the available supply, according to figures announced by the American Medical Association.

New doctors are being graduated from medical schools in the United States at the rate, on the average, of 5,173 each year. The number has remained fairly constant for the past six years. Physicians licensed to practice medicine for the first time average 6,049 each year. The difference between the two figures is accounted for by licenses to graduates of foreign medical schools.

The defense program demands, in connection with training an army of 1,400,000 men, from 7,000 to 8,000 reserve medical officers for each of the next three or four years.—Science News Letter.

COCAINE AS A TOPICAL ANESTHETIC

Paul W. Miles, M.D.*

Newton, Kansas

Nearly all of you have used cocaine hydrochloride on mucous membranes and many of you doubtless have seen some of its erratic effects. On certain persons, it apparently "just won't take." While reading this please reconsider these patients. Perhaps, after all, it was not individual idiosyncracy, but ineffective cocainization.

The time required for cocaine hydrochloride to be absorbed through the walls of capillaries and small blood vessels is very short, and is measured in seconds, not minutes. This means that when the mucous membrane to be anesthetized is erythematous from any cause, cocaine may be removed from the site as fast as it can be added. To reduce or delay absorption of cocaine into the blood stream is not only to reduce the systemic dose, but to greatly increase the local anesthesia.

To reduce such loss by erythema, epinephrin is applied, very logically mixed with the cocaine solution. A very useful preparation can be made by mixing from one to three parts of fresh ten per cent cocaine hydrochloride with one part of 1-1000 epinephrin solution. The resulting mixture is quite potent, and much safer than the usual twenty per cent solution.

To avoid traumatic erythema, the cocaine epinephrin mixture is first sprayed on the mucous membrane, and in two or three minutes re-applied on a cotton or gauze pack directly without rubbing. Even in the pharynx or larynx, a patient will tolerate a pledget of cotton held as a pack for a surprising length of time if it is admitted gently and not moved about. In the respiratory tract, some sure methed of preventing aspiration is necessary.

By considering the fact that as soon as erythema

* Medical Corps, United States Army.



Fig. I.—A, anteroposterior and B, lateral roentgenograms of cervical vertebra at entrance to hospital August 13, 1940. Fig. 2.—Lateral view after four weeks of traction by use of a common head halter. Fig. 3.—A recent lateral view.

appears, the cocaine is removed from the local tissues through the blood stream, the time limitation of topical anesthesia is recognized. Cocaine is highly toxic and irritating to living tissue, and its application is followed by erythema. Furthermore, epinephrin is not indefinitely effective as a vasoconstrictor, and is followed by a secondary erythema. Cocainization should, therefore, be attained in the shortest possible time, and the operation done without delay. If surgery is likely to require more than forty-five minutes after the first application of cocaine, one should be prepared to resort to another anesthetic.

In the throat or respiratory tree, cocainization should require not more than twenty minutes. There are a few crucial minutes when anesthesia is ideal. If this time is lost, no amount of additional cocaine will regain equal anesthesia. In this "theater of operations," it is also wise to use pre-operative atropine to prevent the cocaine being washed away by mucous and saliva, and to minimize trauma by the suction tip. Morphine is not necessary, and is contraindicated in case of respiratory arrest in cocaine intoxication. Pre-operative barbiturate is a necessity.

Anesthesia is best induced in the nasal mucosa by first spraying a cocaine-epinephrin mixture, then gently packing the innervation areas with soft gauze strip wrung out of the same. Surgery can often be done with the gauze still in place, after a pause of less than five minutes. The gauze strip itself may be used as a retractor or dissector in certain procedures. Use of "cocaine mud," a paste made of the crystals in epinephrin solution is not quicker or more effective, and tempts one to use more cocaine than necessary.

The irritating quality of cocaine is best exhibited on the cornea. Cocaine induces edema and fragility, and is, therefore, contraindicated in all diseases of the cornea, except as used for surgical anesthesia. To give cocaine eye drops to a patient for relief from pain following removal of a corneal foreign body is dangerous, as it prevents healing, and promotes infection.

Other drugs like butyn and pontocaine have a similar but lesser effect on the cornea, and likewise should very rarely be used except for surgical anesthesia. At present, I am treating a soldier who accidently became addicted to the use of butyn-metaphen ointment in the eyes a year ago, when it was prescribed for him by a physician. When he fails to use it regularly, his eyes are unbearably painful.

In routine surgery of the eye, edema of the cornea due to cocaine is often seen, and sometimes leads to blistering of the superficial epithelium. This surface is very easily abraded.

A severe reaction of the cornea is fortunately rare. One case like the following, destroys one's confidence in cocain forever:

A white soldier from Texas, W. T. C., aged twenty-five, in excellent physical condition, complained of esotropia of the right eye, present since birth, vision normal. On March 5, 1943, I recessed the right internal rectus muscle, using cocaine five per cent and epinephrin topical anesthesia, with infiltration of the muscle with two per cent procaine. Five minutes after application of the cocaine, the cornea became steamy. Saline was used to keep the cornea moist. A few minutes later, the surface of the cornea appeared like white ground glass, completely opaque. Near the limbus at 7:00 o'clock was an abrasion two millimeters long where it had been lightly touched with the tip of a muscle hook. The total time for anesthetic and operation was twenty-five minutes. Yellow oxide of mercury ointment was applied, and both eyes covered.

Subsequently, I discovered a statement in the Dispensatory of the United States of America, "It is reported that cocaine hydrochloride produces an irritating substance when prescribed with yellow oxide of mercury, presumably due to the formation of a mercuric salt."[1] Whether use of mercury aggravated this reaction, I do not know. I am sure that the cornea was seriously damaged prior to the addition of mercury. The irritating substance probably requires some time to form in a prescription, and has not time to form in the cornea.

In forty-eight hours, the eye was dressed, and found not at all inflamed, although the cornea was still edematous. At the point abraded was a small white spot. Two days later this spot was still present, and was scraped off with a spud. No anesthetic was needed as the cornea was insensitive. Next morning the spot was healed.

The cornea remained partially anesthetic. Perhaps the nerve supply of the cornea was destroyed. On April 19, 1943, the cornea was still edematous, but did not stain with fluorescein. Vision was 20/200, J-9-14, with no improvement upon refraction, plus .25, plus 1.25 x 75.

After five months, there has been no change.

Systemic cocaine intoxication is quite rare, presumably because of routine use of barbiturate premedication. Mild post-operative flurries of excitability are common, but not alarming. Without the protective action of barbiturate, the toxic dose of cocaine may be as little as two grains.

Allow me to present a case in which cocaine reaction very nearly resulted in death. A white soldier from Pennsylvania, R. H. G., aged twenty, entered

1. 22nd edition, 1940, J. B. Lippincott, page 352.

the E.E.N.T. ward May 3, 1943, complaining of epistaxis. He stated that he has not been able to remain in direct sunlight for many years without suffering from weakness, nervousness, dizziness, headache, dyspnea, palpitation, and epistaxis. He has never had these symptoms on a cool cloudy day, or while doing indoor work. He stated that one cousin has the same heat sensitiveness, and that his brother has asthma.

By observation on the ward, the onset of these complaints with exposure to sunlight was observed, and malingering was ruled out. On examination, the patient was a pleasant child-like fellow, about sixty-eight inches tall, weighing 165 pounds. The skin of his chest was always flushed, and often that of his face. The epistaxis came from a spur on a markedly deflected nasal septum, on the left side. There was a healed round sharp edged ulcer scar on the right side of the septum, high up, but the Kahn reaction was negative. The tonsils were enlarged, but not inflamed. The thyroid gland was small. The heart rate was regular and normal. The blood pressure was 120/65. The heart was not enlarged, there were no thrills, the sounds were clear with a short systolic murmur at the apex and base, not transmitted elsewhere. The reflexes were hyperactive. There was no tremor, and the hands felt cold.

The red blood cell count was 5,100,900; the white blood-cell count 6,200. The hemoglobin (Tallquist) was eighty per cent. The percentage of polymorphonucleated white cells was sixty-six per cent. The clotting time was two minutes, the bleeding time two and one-fourth minutes. The urine was amber, acid, clear, with no sugar or albumin present.

I performed a submucous resection of the nasal septum, May 8, 1943. Pre-operative medication consisted of nembutal grains iii, morphine sulphate grains ¼, atropine sulphate grains 1/150. The patient was perfectly at ease during the surgery, which was done in an air conditioned operating room in seventy minutes. Five minutes after returning to the warmer air of the ward, he became uneasy, nervous, frightened. In ten minutes he was frantic, whimpering, "I want to go home, I want to go home . . ." He was given nembutal grains iii orally. In thirty minutes he was violently thrashing about in bed, and required four attendants to keep him from injuring himself. After a few minutes of this, he was frothing and drooling saliva, and became dyspneic and alarmingly cyanotic. He seemed to be fighting for the vertical position, but when he was permitted to sit up, he remained equally violent and cyanotic. By this time intravenous sodium amytal was ready, and grains iii were injected into the vein. The other half of the ampule was immediately injected into the deltoid muscle.

After a few minutes, he seemed a bit quieter, and less cyanotic, but he remained restless and completely out of mental and emotional control for eighteen hours. He did not sleep in spite of the total dose of twelve grains of barbiturate in less than four hours. The following morning he was still weeping and drooling, and moaning, "I want to go home," but he responded better to conversation.

Twenty-four hours later, he was mentally normal. Three days later, he walked in the sun about three minutes, and had a mild spell of weakness and headache. There was no post-operative bleeding, or interruption of healing in the nose. I am convinced that he would have died without intravenous amytal. He was discharged May 22, 1943, to do limited duty.

In conclusion, I have considered in this article the following facts:

1. The fact that cocaine topical anesthesia is much improved if erythema of the mucous membranes involved is reduced.
 a. By mixing epinephrin with the cocaine.
 b. By atraumatic application of the cocaine mixture.
2. The fact that cocaine anesthesia has inherent time factors for inducting ideal anesthesia, and a critical time period after which no additional amount of cocaine can improve the anesthesia.
3. The fact that cocaine in contraindicated for use on the cornea except for surgical anesthesia, when its irritating qualities should be understood. Report of one case of permanent cocaine injury to the cornea.
4. The fact that cocaine intoxication can cause death, and that the specific treatment is intravenous barbiturate. Report of one case of nearly fatal cocaine intoxication.

The strong (seven per cent) tincture of iodine never should be applied to a wound, according to an announcement by E. Fullerton Cook, Phar.D., Philadelphia, chairman of the Committee of Revision of the Pharmacopeia of the United States of America, The Journal of American Medical Association reports in its July 18 issue. The strong tincture evaporates quickly, leaving crystals of free iodine in the wound, which injure the tissues and prevent healing.

According to Dr. Cook, The Journal says, "pharmacists should always sell the U. S. P. Mild Tincture of Iodine for first aid, and not the strong tincture of iodine; neither should they prepare the mild tincture by diluating the strong tincture, for then it will contain potassium iodide instead of sodium iodide, and the alcohol percentage will not be correct. Sodium salts are much better for application to a wound than are potassium salts."

THE TREATMENT OF THE PSYCHONEUROSES OF WAR*

Robert P. Knight, M.D.

Topeka, Kansas

Among the many recent surgical advances two are outstanding — the use of the sulfonamides to combat infection, and the use of blood plasma to combat shock. Both must be used immediately after the injury, and delay may result in loss of the therapeutic opportunity. The importance of immediate treatment for acute war neuroses was the outstanding lesson learned by psychiatrists, too, in World War I. Of 4,235 cases treated quickly and energetically in the receiving centers just behind the lines in France, Dillon,[1] a British psychiatrist, reported 63.5 per cent returned to duty in a few days to a few weeks, with only five per cent relapses. But cases evacuated to base hospitals in England or America afford a dismal contrast. The symptoms became fixed and chronic and the compensation program completed the damage. 68,000 neuropsychiatric casualties—fifty-eighty per cent of all living World War casualties of whatever kind—are still being cared for in Veterans' Hospitals in this country; and the average cost of treatment from onset of the neurosis until death is $30,000 per patient.

The American College of Surgeons is to be congratulated for taking account of the war neuroses in scheduling these splendid one-day programs. A similar program at this stage of the war of 1914-18 would have included no such topic. However, one must hope that scheduling it for this session—under "treatment to be given after evacuation from combat zones to hospitals in this country," rather than under "treatment to be given in combat zones," along with wounds, injuries, burns and shock which require immediate treatment—does not mean that the lesson of immediate psychiatric treatment for war neuroses has been forgotten. Because of the crucial importance of this factor of immediate treatment I shall violate the injunction of the program chairman to confine the discussion to treatment after evacuation to this country, and shall include also discussion of diagnosis, early active treatment, prognosis and the complications of treatment after evacuation.

DIAGNOSIS

The psychoneuroses of war are identical with the traumatic neuroses of civil life except for the character of the trauma. They were called "shell shock" during most of World War I, a term coined by a British pathologist, Col. Frederick Mott, who regarded them as organic conditions produced by minute, petechial hemorrhages of the brain. It was finally realized that a very small percentage of cases had any such petechial hemorrhages, and indeed that many so-called "shell-shock" cases had never been near an exploding shell. So this term has been discarded and the designation "war neurosis" or "traumatic neurosis of war" is the approved term.

A wide range of psychiatric conditions falls under this category — in fact, practically every functional psychiatric condition seen in peace time. It is expected that the neuroses of this war will be similar to those of 1914-18, except that, because of the more terrifying combat conditions of this war due to aerial bombing and mechanized warfare more anxiety states are anticipated; and along with the peace-time trends fewer hysterias and more psychosomatic conditions such as peptic ulcer, hypertension, effort syndrome and gastro-intestional organ neuroses might be expected. Dillon reported the following percentage grouping of cases:

70 per cent—Direct fear or anxiety states—generalized shaking, nervousness, "jumpiness," with occasional dizziness and headache.

20 per cent—Hysterical conversions—functional paralyses of arm or leg, mutism, functional blindness or deafness, etc.

10 per cent—a. Confusion and stupor. b. Amnesia and fugues. c. Combined forms—war neuroses with organic disorder or previous neurosis reactivated.

Glover,[2] another British psychiatrist, reporting on the casualties of this war, lists in order of their frequency three main types:

1. Anxiety states.
2. Physical and emotional fatigue or tension (neurasthenia).
3. Effort syndrome (D. A. H., soldier's heart, neurocirculatory asthenia).

Brussel and Wolpert,[3] reporting on 282 consecutive psychiatric admissions over nineteen months of soldiers in training, list:*

44 per cent—Anxiety states, with complaints of precordial pain and nervousness.

24 per cent — Conversion hysterias, with complaints of abdominal pain, stomach trouble, headache, and other pains.

23 per cent — Reactive depressions, with complaints of worry and/or depression.

18 per cent — Neurasthenia, with complaints of dyspnoea, weakness, fainting spells, backache, fatigue.

6 per cent—Effort syndrome, with palpitation and cardiac anxiety.

* Read at the War Session of the American College of Surgeons, Kansas City, April 1, 1943.

* These percentages total over 100 per cent, probably because some cases were given two diagnosis and were listed under both.

2 per cent—Obsessional-compulsive states.
2 per cent—Mixed conditions.
.4 per cent Hypochondria.

It was noteworthy observation in 1914-18 that an insignificantly few cases of war neuroses had any physical injuries. Furthermore, those who were wounded or injured did not usually develop a war neurosis, execept for a few who had recovered from their injuries and were about to be sent back to fight. Hence, it can be said with some assurance that a casualty who shows no external evidence of injury and has no signs of internal injury should be regarded as a psychiatric casualty and given early psychiatric treatment. One of the errors of the last war was to neglect such cases because they "had nothing wrong with them."

THE PSYCHOPATHOLOGY OF THE WAR NEUROSIS

Understanding the psychopathology of the war neurosis is an essential prerequisite to proper treatment; and understanding the war neurosis requires an appreciation of the concepts of stress versus tolerance in each of us as human beings. None of us in this room knows just how much and what kind of stress he can stand and still keep functioning. In any one of us the degree of tolerance of stress varies from time to time; and, furthermore, there is an important qualitative factor operative, in that each person is more vulnerable to specific kinds of traumatic experiences, depending on his own particular disposition and past experience. Some of us function with considerable margin of reserve in respect to what we could stand in the way of traumatic experiences—deaths of relatives or friends, financial losses, injury or illness, loss of prestige through failure, frightening experiences, deprivation of food, water, sleep, separation from home and routine and re-adapting to an entirely new set of conditions, and so on. Many others manage to function fairly well under favorable conditions but show signs of decompensating emotionally under stress. Others have outright emotional illnesses and stop functioning normally. Men in the armed forces are subject to every one of the above-named stresses and many more. Some break down in training, without ever seeing any combat duty. Of those who do not, some more will not be able to tolerate psychologically the separation by great distances from home and the terrifying experiences and threats to life of actual combat. The conflict between such dangers and threats to life on the one hand and the demands of courage, duty, patriotism and discipline on the other is a severe one. We have finally learned to teach men during training that acute fear is normal and not cowardly. But the controlling mechanism which keeps a man functioning as he has been trained in spite of his acute fear may break down during a traumatic experience. If it does, he develops an acute anxiety state or an hysterical paralysis or blindness or aphonia in reaction to the too dangerous or terrifying experience. Or the entire environmental stress of potential danger, strange surroundings, continual uncertainty, separation from family or friends on whom he depended in order to get along, may be traumatic without any specific terrifying experience so that he breaks down into a cardiac neurosis, or a neurasthenia or a depression. The stronger the factor of predisposition to neurosis (which is the same as a narrower margin of psychological reserve) the less severe need be the traumatic experience or environmental stress to cause the individual to break down.

The characteristic symptoms of a neurosis precipitated by a terrifying experience are acute emotional tenseness and restlessness — or the opposite, emotional apathy and listlessness—, fixation on and preoccupation with the vivid details of the traumatic event — the deaths of comrades, the conflict over whether to save one's self or risk one's life to help another, the narrowly escaped annihilation, the endless period of exposure to danger—,terrifying dreams which relive the experience and prevent recuperative sleep, a general reduction of all functional activity, a need to hang onto someone and talk to him and be protected by him, and an acute irritability and tendency to burst forth with violent aggressive actions. Rescued merchant seamen whose ships have been torpedoed and the evacuated casualties of Pearl Harbor and Guadalcanal provide the main American psychiatric experience of this war so far. There will be many such psychiatric conditions among the men in the armed forces before long. Psychiatric casualties are said to constitute about thirty per cent of all casualties from combat areas.

TREATMENT

A. Immediate treatment. All war neurosis casualties should be removed at once from the actual combat zone to a receiving center behind the lines where a program of treatment can be started at once (within twenty-four to forty-eight hours of the onset). This program should consist of the following:

1. Rest in bed, with sleep promoted by hypnotic drugs, as needed.
2. Supportive treatment as indicated—fluids, nourishment, etc.
3. Continuous attendance by nurses, especially when the patients may wake up from a nightmare. Reassurance and psychological and/or pharmacological aid in going back to sleep should be given.
4. During waking hours the presence of attending personnel is desirable to provide a sense of se-

curity and a listener to whom the patient may express his fears and recount his experience.

5. As soon as the patient is recovered from exhaustion and deprivation (which will be from the beginning in the case of neuroses not precipitated by terrifying experiences) psychotherapy should be begun. This may consist of reassurance, exhortation, support, encouraging verbalization of the patient's fears and of his particular intolerable stress, or may consist of hypnosis with recovery of the frightening memories and their assimilation by him, aided by support and hypnotic suggestion by the therapist. Recovered amnesic memories are, by hypnotic suggestion and by re-telling in the post-hypnotic state, brought into complete conscious awareness. With this goes also a kind of re-education in which the therapist helps the patient to see and understand what happened to him, what the psychological escape and protection value of the neurosis is, how his fear-controlling mechanism broke down and how it may be restored. Hysterical cases with paralysis may be treated at once by powerful suggestion and use of the faradic current, and may frequently be cured of the paralysis in one treatment, but it is important that they not be sent immediately back to duty without having been re-educated as to the meaning of the symptom and having been given some insight into their own reactions, or a quick recurrence or onset of a more stubborn form of neurosis is to be anticipated. Hypnoanaylsis, with forced recall of traumatic experiences and verbalization of fears, may be more effective with some cases which resist other measures. Group psychotherapy—exhortation, explanation, re-education — or even group hypnosis may be undertaken when there are too many patients for the therapists to spend sufficient time with individually. During group hypnosis the therapist may spend a few minutes of specific therapy with each subject, making suggestions and remarks pertinent to his particular case.

The neurasthenic case may be treated more effectively by direct psychotherapy, without hypnosis, the attempt being made to develop specific insights into the value of the neurotic reaction for his particular case, the general and specific meanings of his individual symptoms, without resort to condemnation and accusations of goldbricking which would only cause the symptoms to become more severe and more firmly fixed. The policy of studied neglect of and out-spoken contempt for such cases pursued by some medical officers is not therapeutic and usually results in making the neurosis far more treatment-resistant for the therapist who later attempts the proper kind of psychotherapy.

6. All cases of war neurosis, insofar as it is feasible, should, after recuperation from the early exhaustion and deprivation, participate in planned recreation and useful activities rather than be permitted to sit or lie alone and brood over their own preoccupations.
7. With the recovery of self-confidence, relief from insomnia and anxiety dreams, and achievement of some insight, the patient may be discharged and sent back to combat duty, or, in certain instances, have temporary or permanent non-combat duty recommended by the psychiatrist on the basis of his estimation of the potentialities and state of recovery of the patient.
8. Only those cases which do not respond to immediate treatment over a period of a few weeks, and the psychotic cases, should be evacuated to base hospitals.

B. Treatment after evacuation. In the base hospitals one may expect to see three types of psychiatric patients: (1) Those cases of war neurosis which through mis-diagnosis, neglect or lack of facilities received no or inadequate immediate treatment at receiving centers; (2) those cases of war neurosis which proved resistant to all early attempts at psychiatric treatment; (3) cases of psychosis. In any event, the evacuated cases will have the additional factor of chronicity and greater fixation of symptoms, plus the important secondary gain or "sickness profit" of escape from danger and duty and return to safety through illness. Face-saving mechanisms will require that they not recover too fast, and considerations of pensioning and discharge further complicate the situation. Hence, treatment undertaken after evacuation will be carried on within a quite different framework of circumstances and psychological forces from that undertaken immediately after the onset and removal to a receiving center. Furthermore, it will have a different therapeutic aim. The immediate treatment had the aim of restoring the patient to combat duty. The late treatment has as its aim, in view of the policy of the armed forces of discharging such casualties into civilian life as quickly as possible, the aim of rehabilitating the patient so that he may leave the hospital and re-enter civilian life in a productive capacity.

After evacuation considerations of urgency and quick restoration are not so imperative, insofar as the patient's value to the armed forces is concerned, although of course there are still present all considerations of effective salvaging of human happiness, productiveness and mental health. Understaffing of

Veterans' Hospitals by psychiatrists plus far-reaching complications attendant on disability compensation and discharge status have resulted in loading psychiatric wards with chronic war neuroses receiving little more than custodial care, at huge expense to the taxpayer for both the care and the disability compensation. Approximately one billion dollars were expended by the government from 1923 to 1940 for neuropsychiatric casualties alone and the end is not in sight, for some four or five thousand new cases from World War I are admitted each year. This presents a staggering prospect for psychiatric casualties of the present war unless two major improvements in their management are brought about: (1) The carrying on of an active, well-rounded program of psychiatric treatment for all such casualties instead of mere custodial treatment; and (2) the elimination of the complications incident to continuing financial compensation (pension) for disability.

1. A program of psychiatric treatment.
 a. Careful history taking and complete examination, including psychological testing.
 b. Individual prescription of treatment methods based on the examinational findings and the test results.
 c. Occupational therapy which should be combined with vocational training and education wherever possible. This will require a far greater elaboration of facilities and personnel than has been provided in Veterans' Hospitals in the past.
 d. A program of recreational therapy, both indoors and outdoors, which should have as its purpose the drawing into normal activity and enjoyment of those inhibited and locked up energies which are shackled by the chronic neurotic process. Both the occupational and recreational therapy should be adapted to the individual patient's needs insofar as this is possible.
 e. Psychotherapy of an active type should be carried on by a staff adequate to the number of treatable patients. This may be by individual treatment or group treatment. Reeducation, direct attempts to establish rapport and give insight, hypnosis, hypnoanalysis, occasionally psychoanalysis may be attempted.
 f. Shock treatment—insulin, metrazol or electroshock might be attempted with suitable cases
 g. Establishment of out-patient service, with dispensary care and partial productive functioning of patients residing in supervised boarding homes would serve to reduce the load on the hospital staff.

2. Elimination of continuing disability payments (pension). It is psychologically incorrect to say that a person falls ill in order to collect disability benefits from the insurance company or from the government, but it cannot be escaped that recovery of a psychoneurosis is greatly complicated when payments for being sick continue as long as the sickness lasts and cease when the person recovers. This is as true in peace time as in war time, and the same recommendation applies to both the insurance companies and the government: Neurotic disabilities should receive either no compensation or compensation in a lump sum; the system of continuing payments with cessation on recovery serves as a powerful barrier to recovery. Organic psychiatric conditions and psychoses should probably be excepted from this recommendation, but the psychoneuroses certainly should not. There are enough "advantages" to being neurotically ill — being relieved from responsibilities, being protected and cared for, and so on—without adding the element of financial gain to be unconsciously exploited by the patient.

SUMMARY

The psychoneuroses of war comprise a high percentage of all war casualties and have the additional property of developing chronicity and resistance to therapy if they are not treated promptly and adequately. The most successful results may be obtained by rest, support and psychotherapy carried out near the combat zone instead of after evacuation to a base hospital. For cases which must be evacuated, a well-rounded program of active psychiatric treatment and elimination of the complications incident to continuing disability benefits are recommended.

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"OUT FOR THE DURATION—BACK IN '44"

"Would that my eyes were as of yore,
My oculist has gone to war.
I must not let my throat get sore,
My throat doctor has gone to war.
Your veriform appendix you . . .
Don't act up any more . . .
Let us postpone our rendezvous
Till everything's not so askew.
Till nurses and surgeons by the score,
Have all come trooping back from war."
A.W.V.—Kansas City Star.

President's Page

To the Members of the Kansas Medical Society:

No single group or profession in the United States has responded, on a voluntary basis, as has the medical profession. Now with our men scattered to the four corners of the globe there has been introduced into Congress, the Wagner-Murray bill which strips the right of free enterprise from every physician, hospital, dentist and nurse and places under the supervision of one man, the Surgeon General of the United States Public Health Service, complete domination of every activity. Regardless of his fine record or standing, to place such supervision in the hands of one man means the rankest type of autocracy.

I trust that every physician in Kansas and every medical society shall immediately protest to their Congressman and Senator; that you will explain to your friends the intent of this bill and that they likewise will file their protest.

A quotation from Winston Churchill covers this subject very well: "We must beware of trying to build a society in which nobody counts for anything except a politician or an official, a society where enterprise gains no reward and thrift no privileges."

Sincerely,

J. L. Lattimore M.D.

President, The Kansas Medical Society

EDITORIAL

NARCOTICS IN KANSAS HOSPITALS

A decision has been reached in regard to narcotics in Kansas Hospitals which has been pending since July 1, 1943. Mr. Will S. Wood, deputy commissioner of narcotics of the Treasury Department, Bureau of Narcotics, in Washington, D. C. writing Mr. Joseph Bell, district supervisor of the Kansas City office had the following to say:

"Reference is made to your letter of August 5, 1943, enclosing a copy of an opinion of the Attorney General of Kansas, in connection with the registration of hospitals under the Federal narcotic law.

"In view of the Attorney General's opinion, you may approve applications for registration of hospitals in Kansas providing that the application is executed by a duly qualified physician, who will have complete control of and assume responsibility for all narcotic drugs in the hospital.

"Of course, you should not approve applications executed by osteopaths, inasmuch as osteopaths in Kansas are not entitled to dispense narcotic drugs."

The letter referred to was that written to Mr. Bell from Mr. A. B. Mitchell, the Attorney General of Kansas and reads as follows:

"This office has been asked to review the Kansas laws as they bear upon registrants or licensees under the federal narcotic act. The occasion for this request is the sequence of events detailed as follows:

"First. The bureau questioned the authority of hospitals in Kansas under Kansas law, to register with the federal government under federal act of December 17, 1914, as amended.

"Second. This office in response quoted the provisions of G. S. 65-615 and 616 of the Kansas statutes, which list only physicians, dentists, veterinary surgeons, registered nurses and registered pharmacists as exceptions to the penal provisions therein.

"Third. No amendment to this Kansas law was made either by the 1941 legislature or the 1943 legislature, although the amendment to include the hospitals within the exception was suggested by the bureau and others.

"Fourth. In June of 1943 the Internal Revenue Department notified hospitals in Kansas, which had theretofore been registered for narcotics, that under an opinion from the Attorney General's office the hospitals in Kansas were not entitled to be registered and would not be registered on July 1, 1943.

"Although it may not be indicative upon any legal question herein presented, we call attention to the fact that the federal narcotic act, of December 17, 1914, as amended, and the Kansas act, which makes it unlawful to have narcotics in possession, with certain exemptions, was passed in 1921. Our understanding is that hospitals have been registered in this state under the federal act since that law went into effect up until the present time, and without reference to the Kansas act which became effective in 1921.

"The opinion which this office gave on February 28, 1942, did not say that a hospital which was used as a repository for narcotics, registered under the federal act, was per se a violator of the Kansas penal statute, but merely quoted the Kansas law, and it was upon such citation and consideration of the Kansas law that the federal authorities refused to register hospitals in Kansas.

"Our view of the Kansas law is that any person other than a physician, dentist, veterinary surgeon, registered nurse or registered pharmacist, as provided in the Kansas act, may not have lawful possession of any opium, coca leaves or any compound, salt, derivative or preparation thereof, and that the dispensing or distribution of narcotics must be in compliance with G.S. 65-616.

"Under the Kansas decision, lawful possession can be acquired only through proper federal agency. (State v. Miller, 126 Kan. 578 and State v. Miller, 127 Kan. 487.) It is the understanding of this department that drug stores as such are registered by the federal agency through registered pharmacists or physicians. Being so registered they would constitute in fact agencies of the federal government for the lawful distribution and dispensation of narcotics and would have lawful possession of such narcotics. Acting thus as repositories they could not be classified as having unlawful possession under Kansas law.

"This department can find no premise on which to draw distinction between a drug store acting as hereinbefore described, and a hospital acting in a similar capacity.

"Those persons named as exceptions to the penal provisions of the Kansas act may, under present federal procedure, register a repository to act under federal law for the proper and lawful dispensation and distribution of narcotics without offending the penal provisions of the Kansas statutes."

The cooperation of these three officials has finally straightened out a problem which treatened to complicate the administration in all the hospitals in Kansas. The opinion is particularly gratifying to the officers of the Society who have been attempting to assist in straightening this matter out.

THE KANSAS QUOTA

The July 7 issue of the Journal of the American Medical Association on its editorial page carries in a box the following information "6,000 more yhpsicians needed now," and under the title of "More Doctors Needed for the Armed Forces" this editorial follows:

"At a conference of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians, held on July 31, with the War Participation Committee of the American Medical Association and in the presence of Mr. Paul V. McNutt, chairman of the War Manpower Commission, and representative of the Army and Navy medical departments and the Public Health Service, it became apparent that the medical profession must produce toward the winning of the war an additional six thousand physicians for the armed forces before January 1, 1944. Pursuant to a realization of this objective a directive has gone to the generals in command of the various service commands authorizing them to induct into the service physicians between the ages of 38 and 45 who have been declared available by the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians and who are otherwise subject to Selective Service.

"The needs of the armed forces are real. The members of the War Participation Committee raised with the representatives of the various governmental agencies all the questions that have from time to time challenged the need; the challenge seems to have been met effectively. Indeed, the intimation was made clear that the needs of the armed forces will be met by specific regulations of the Selective Service Administration or the enactment of necessary legislation if required. All physicians up to 45 years of age who have been indicated as available have therefore placed on them now the responsibility for an immediate decision as to their enlistment with the armed forces. The need is so positive that questions of essentiality of men in positions of teaching and research and in industrial medicine are likely to be rigidly reviewed in the near future with a view to extracting from civilian life every one that can be spared.

"As the war continues and intensifies, new needs for the services of the medical profession become apparent. An army in motion and one engaged in the kind of aggressive combat that now concerns our armed forces needs physicians in even greater numbers than have heretofore been demanded. Many thousands of interned aliens and prisoners are now the burden of the United States and must be given medical care.

"If there is any physician who still hesitates under these circumstances, he should realize the added advantage to him of accepting now the commission that is proffered. Should it become necessary in the near future, as seems quite likely, to enlist new activity by the Selective Service Administration and the Officer's Procurement Service to bring in the six thousand physicians that are so certainly required, those recruited by that technic will inevitably begin their service with the minimum commission that is offered, namely that of first lieutenant. Until that technic is installed, the men of special competence and of years beyond those of the recent graduate have the assurance of careful consideration and a commission more nearly in accord with age and experience.

"The call here made has the approval of the Directing Board of the Procurement and Assignment Service and of the War Participation Committee of the American Medical Association. The medical profession may well be proud of the fact that it has been the only group given, by directive of the President, the responsibility of maintaining service in civilian life and at the same time supplying the needs of the armed forces. Let us not fail in meeting fully the trust that has been placed upon us."

Dr. F. L. Loveland, chairman of the Kansas Committee on Procurement and Assignment wired for information regarding the quota for Kansas. He received the following reply from Dr. M. E. Lapham, executive officer of the National Board of Procurement and Assignment Service for physicians, dentists and veterinarians of the War Manpower Commission: "In reply to your telegram of August 5, our records indicate that the total quota of physicians to be recruited from Kansas for 1943 is 460, and that the state has been credited with 404 physicians on extended active duty, leaving fifty-six still to be recruited."

With only fifty-six to be recruited Kansas will have again filled her quota as she did in 1942. It is believed that the discrepancy in our number of men in service with that number as given by the War Manpower Commission lies in the fact that some few of our members were living in other states at the time of entrance into service as interns or resident physicians and these states have been credited with their enlistments, when in reality these men have asked that their names be entered on the Kansas military roll as their Kansas membership was in effect prior to military service. Also our list contains some doctors of medicine who have entered the service directly after graduation. These men have not practiced in any state but their families live in and their legal residence is in Kansas. Some of these last are sons of Kansas physicians, and have graduated from eastern schools.

THE POLIOMYELITIS EPIDEMIC IN KANSAS

One hundred seventy-nine cases of poliomyelitis (infantile paralysis) were reported in Kansas by August 14 with 24 known deaths in the counties of Douglas, Shawnee, Wyandotte, Marshall, Mitchell, Labette, Harvey, Riley, Montgomery, Reno, Sedgwick, Stevens and Sumner. According to Dr. C. H. Kinnaman, director of the division of epidemiology of the Kansas State Board of Health, this is the worst epidemic of the disease in the state, exceeding even the previous peak years of 1930 and 1940.

At the end of the month of August, 1930, there were 185 cases reported and for September, 272 cases with sixty-eight deaths reported for the entire year. In 1940 there were 166 and in September, 197 cases with forty-one deaths for the year.

The following counties in the state have reported cases:

Allen—1	Jackson—1	Ottawa—1
Anderson—1	Jefferson—4	Pottawatomie—2
Butler—2	Jewell—1	Reno—10
Cherokee—1	Johnson—10	Rice—1
Clay—1	Labette—13	Riley—1
Coffey—2	Leavenworth—1	Saline—7
Cowley—3	Linn—1	Sedgwick—62
Crawford—3	Marshall—11	Shawnee—6
Douglas—2	Meade—1	Stafford—1
Finney—1	Miami—3	Stevens—1
Ford—1	Mitchell—1	Sumner—4
Geary—1	Montgomery—4	Wilson—1
Harvey—2	Neosho—1	Wyandotte—9

Dr. Kinnaman sent out the following to all physicians in the State: "The occurrence of cases of acute anterior poliomyelitis is on the increase in Kansas. From present indications this disease will be prevalent in many communities during the months of August, September and October. Where cases of poliomyelitis occur in any community the public becomes thoroughly alarmed and many rumors originate regarding the number of cases. In order that correct information be available to the State Board of Health regarding the (poliomyelitis) situation over the state, it is requested that every physician notify his local health officer promptly of any case of this disease coming under his care. Be on your watch for any suspicious cases."

The State Board of Health is attempting to cooperate in all ways possible and it is hoped that the epidemic will not exceed the peak years, but the crowded facilities in the war production centers of the state of California, Texas and Oklahoma, have possibly contributed to the epidemic existing in those states at the present time and may result in a similar situation in Kansas.

The National Foundation for Infantile Paralysis has advised the Board of Health that it is sending two teams to Kansas to assist with the Kenny method of treatment for paralysis victims. It is possible that these teams will be stationed at the Hospital of the University of Kansas School of Medicine at Kansas City and in Topeka or Hutchinson. It is planned that this type of treatment will be conducted in five centers in the state, namely in Kansas City, Topeka, Hutchinson, Wichita and Hays. Additional plans are going forward to make 200 beds available for use of those contracting the disease where they may be isolated and given the treatment immediately upon diagnosis of the disease.

The Board of Health has also sent out the following practical information on the disease:

"The disease is due to a filterable virus with early symptoms of digestive disturbance, fever, mental dullness, headache, sore throat, and sometimes convulsion which is followed by weakness or paralysis in some of the muscles of the limbs, abdomen or face. Some cases appear without digestive disturbance or sore throat. The onset of the disease may be gradual or sudden. Although there is no known method of immunization against the disease there are many precautionary measures which may be taken.

"Do not attend unnecessary gatherings.

"Avoid personal contact — as kissing and handshaking.

"Do not handle pets.

"Guard against insect bites.

"Avoid using drinking or eating utensils outside the home.

"Keep physically fit — get proper exercise, food, fresh-air and sleep.

"Do not over exert. Watch out for fatigue.

"Do not swim in congested pools.

"Avoid operations on the nose and throat at this time."

The incubation period of the disease is believed to be from seven to fourteen days. All cases or suspected cases should be reported to your local health officer at once for observation. Where the disease has appeared in a home all persons coming in contact should immediately be quarantined. Although it is usually considered that the disease is one of youth with the ages from a few months to ten years as the most susceptible, cases in the state have been fatal in young women of 25 years, 22 years and a boy 17 years of age.

The local chapters of the National Foundation for Infantile Paralysis are sponsoring the training of physicians and nurses in the Kenny method of treatment. From Topeka the local chapter has sent Dr. M. M. Gill and Dr. R. W. Emerson for training in the Kenny short course which is given at the University of Minnesota School of Medicine. Eight nurses have also been sent for the short course from Christs, St. Francis and Stormont Hospitals and from the city-county public health department. Dr. E. G. Padfield of Salina and Dr. D. C. Barrett, Health Officer of Independence are also attending the course. The following have attended the course at some time previous: Dr. Paul C. Carson of Wichita, Dr. Guy R. Walker of Hutchinson, Dr. F. E. Coffey of Hays, Dr. Charles Rombold of Wichita, Dr. Fred Mayes, Director of the Division of Child Hygiene of the Kansas State Board of Health and Dr. A. E. Bence of Wichita, and Dr. T. C. Kimble of Miltonvale. Another short course for physicians will be conducted in Minnesota in October.

In cooperation with the Kansas State Board of Health and the National Foundation for Infantile Paralysis in the various counties in the State, the Kansas Crippled Children's Commission has agreed to assist in the rehabilitation of victims of the disease, accepting indigent children for treatment on date of diagnosis of the disease rather than waiting until the child has become a cripple due to the effects of the paralysis. It is believed that cooperation of the profession, the Kansas State Board of Health, the Kansas Crippled Children's Commission, the National Foundation for Infantile Paralysis and their local chapters will result in at least a great reduction of the crippling effects on the victims in the State.

Every once in a while some super-patriot whose major contribution to the war effort is thunderous applause at pictures of the Army and Navy in action sounds off to the effect that doctors in the armed forces have a "soft job"—officer's rank and privileges and no danger. This mistaken idea—all too commonly held—is highly unjust to the thousands of medical officers who are risking their lives along with the troops in every combat zone.

Wherever fighting units go, the Medical Corps goes too. There were doctors in the fox holes of Bataan, in the jungles around Milne Bay, in besieged Corregidor. Medical officers have gone down with their ships at sea, been wounded on the battlefield and fallen prisoner to the enemy. Whatever hazards combat units face, the Medical Corps shares.

Death and danger are no strangers to the doctor. They are familiar adversaries, though they come in different guise on the battlefield than in the sickroom.—Journal Medical Society of New York County.

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MEDICAL SCHOOL

MULTIPLE HEPATIC ABSCESSES IN TYPHOID FEVER WITH RECOVERY

Ralph H. Major, M.D.*
Kansas City, Kansas

Liver abscesses occurring in the course of typhoid fever are relatively rare. Louis, in his classic work on typhoid fever, describes a case of multiple abscesses of the liver seen at autopsy. Hoelscher in 1891 found six examples of liver abscess among two thousand cases of fatal typhoid fever on whom autopsies were performed. In 1900 Osler described one case of typhoid fever with multiple liver abscesses and remarked that it was "the only instance of abscess of the liver in our service during the ten years." von Eberts in 1911 collected thirty cases from the literature. In nine cases the typhoid bacillus was isolated from the abscess, while in the remaining twenty-one cases the abscess occurred in association with or following typhoid fever, although Bacillus typhosus was not isolated from the abscesses. In the series of nine cases in which the typhoid bacillus was isolated, all showed single large abscesses, all were operated on, seven recovered and two died.

The following case is of interest because of the rarity of multiple abscesses of the liver in typhoid fever and also because the patient recovered without drainage of the abscesses.

CASE REPORT

G. P., female, married, age twenty-seven, of Mexican origin. Admitted to the University of Kansas Hospitals on November 25, 1942, complaining of chills and fever.

Family History.—Patient's brother, sister and small child were in this hospital at the time of the patient's admission, all suffering from typhoid fever.

Personal History.—Unimportant.

Present Illness.—Onset three days before admission with a chill followed by an elevation in temperature. Since that time patient has had diarrhoea, three to four loose stools daily.

On admission the patient's temperature was 104 degrees, pulse 120. Spleen palpable. W. B. C. 3,050. Widal reaction positive in a dilution of one to 300. Two blood cultures were positive for Eberthella typhi (B. typhosus) on December 26. The blood culture taken on December 4 was positive and a

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stool culture at the time of admission was also positive for Eberthella typhi (B. typhosus).

The patient ran a typical course showing on several occasions an eruption of rose spots. The temperature became normal on December 20 and remained so for ten days. On December 30 the fever reappeared, the patient complained of pain in the right upper quadrant of the abdomen. She continued to have an irregular temperature, rising at times to 105 degrees and accompanied frequently by chills. A tender irregular mass became palpable in the right upper quadrant of the abdomen. Intravenous gallbladder dye test showed a non-functioning gallbladder.

The patient was transferred to the Surgical Service with the tentative diagnosis of acute cholecystitis or hepatic abscess. Operation was performed on February 10, 1943, by Dr. Thomas G. Orr. At operation the liver was found to be definitely enlarged and the seat of numerous small abscesses. No collections of pus around the liver. Two of the abscesses were aspirated and a yellowish material resembling pus obtained. Operative diagnosis — multiple abscesses of the liver. Cultures from the abscesses showed a pure culture of Eberthella typhi.

Following operation the patient had a somewhat stormy course. The patient was given daily doses of six to eight grams of sodium sulfadiazine and later sodium sulfapyridine intravenously. The patient's temperature became normal on March 7 and sulfonamide therapy was discontinued on March 14. The highest blood sulfathiazol level observed was 6.4 mg. per 100 cc. The patient was dismissed from the hospital April 10 in excellent condition. Two months later she was seen and appeared quite well.

Comment.—Recovery from any type of multiple hepatic abscess is rare. Multiple abscesses of the liver due to E. typhi are so rare that the reported number gives us inadequate data upon which to base mortality statistics. This case is notable as an example of recovery from multiple hepatic abscesses caused by E. typhi. It is impossible to conclude that recovery was due to sulfonamide therapy since we have no adequate statistics on the mortality in this disease. However, we observed recovery following continued sulfonamide administration.

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TUBERCULOSIS CONTROL

BREAKDOWN IN EARLY TUBERCULOSIS

The prevalent opinion that the finding of active tuberculosis in a minimal stage warrants an excellent prognosis is true only when adequate treatment follows at once. Many of the favorable reports have come from sanatoria, where the outlook upon minimal pulmonary tuberculosis is not the same as that in the clinics at the time of the early diagnosis.

In sanatoria the number of minimal cases has not increased in direct proportion to the number of cases found on the outside. Failure to see and follow many diagnosed cases may explain the sanatoria impression. Some individuals who reach the sanatorium with minimal disease may show no unfavorable progression even though weeks or months elapsed between the time of discovery and the beginning of institutional care. These are the more resistant cases. Conversely, a significant number of patients found in surveys, and particularly among those in contact with sputum-positive tuberculosis, demonstrate low resistance and a rapid progression of their disease before sanatorium care is finally sought and obtained.

In the Henry Phipps Clinic, Philadelphia, Pennsylvania, even though the serious potentialities of minimal pulmonary tuberculosis are recognized and the physicians and nurses endeavor earnestly and persistently to overcome obstacles that prevent adequate care of these patients, results are astonishingly poor. A study of minimal cases has revealed that almost half developed progressive disease — true of both white and colored patients. Mortality figures were twenty-five per cent for the colored and six per cent for the white patients. Only one of the cases that died had obtained sanatorium care, and then only when already progressed to an advanced stage.

What causes the poor results? The dominant factors will, largely, be applicable to most localities.

First, the diagnosis: It is universally accepted that the x-ray is the most efficient method. Visualizing the minimal lesion is not difficult, but evaluation of its status is not so simple or foolproof. There are three categories: (1) Lesions whose appearance indicates active, unstable disease, (2) lesions considered of doubtful significance and, (3) lesions whose x-ray appearance suggests that complete healing has occurred.

Determination of the character of a lesion is based to a large extent upon experience with previous

similar lesions observed over long periods. Interpreting the objective film is a distinctly subjective procedure, and is of prime importance since it influences recommendations for treatment. Many chest experts advocate the follow-up of contact cases for a period of at least two years after known exposure ceases. It is obviously as necessary to follow for a similar period those cases in the second and third categories mentioned to insure their diagnosis of stability.

Of the nearly fifty per cent of the institute's minimal cases that showed progression of the disease, eighty-six per cent developed extension within the first year, the remainder within three years. Serial x-ray studies enable the clinician to determine at the earliest time those cases in which the original estimate of the lesion's stability was faulty.

Following the diagnosis a strong rapport between physician, nurse and patient is essential. The psychological reactions of the patient to his disease and its treatment depend on the confidence he has in his medical advisers. It is difficult to convince a symptomless patient, often one who was found by survey means and not by his own seeking, to accept such "drastic' treatment as absolute bed rest. He often scoffs at the diagnosis, claims to feel well, and refuses to cooperate.

People in contact with sputum-positive tuberculosis may submit to examination merely for the comfort of being told they are free of the disease. When their hopes are dashed and they are confronted with their own unsuspected trouble, they may turn antagonistic and refuse to accept advice.

Again, society has done little to solve the problem of the family head who must leave behind a situation of destitution for the ones he loves by accepting treatment which must necessarily be a prolonged hospitalization.

Assuming that all these deterrents to treatment have been removed, the actual obtaining of hospital care is in many communities still a great problem. growing greater due to wartime shortages of materials and personnel. Institutions that require positive sputum before admitting a patient are inviting dangerous progression before making available the badly needed bed. The tendency to regard minimal cases lightly, treat them insufficiently, is far too prevalent and often leads to inexcusable relapses. Reliance on the standards of twenty years ago that call for dependence on physical signs to determine the stability of lesions defeats the whole purpose of early diagnosis surveys, since the case without clinical manifestations will receive neglect instead of the treatment and close supervision it deserves.

Early diagnosis is meaningless unless it leads at once to intelligent handling, prompt care and adequate follow-up, with eventual recovery and maximum rehabilitation the goal. — *From Tuberculosis Abstracts Breakdown in Early Tuberculosis, Samuel C. Stein, M.D., Public Health Nursing, March, 1943.*

NEWS NOTES

POST GRADUATE COURSE ON DISEASE OF THE LUNGS

The Kansas State Board of Health in conjunction with the Kansas Tuberculosis and Health Association, the Extension Division of the University of Kansas School of Medicine and the Committee on Control of Tuberculosis of the Kansas State Medical Society are sponsoring a post graduate course on diseases of the lungs, similar in type to the post graduate course on tropical medicine held sometime previously, which will be held in various sections of the state during the week of August 28 to September 5, inclusive.

Speakers who have been secured for the course are as follows: Dr. C. C. Birkelo of Detroit, Michigan, and Dr. Henry C. Sweany of Chicago, Illinois.

It is the plan of the committee in charge of arrangements for the courses to cover the following subjects in so far as posible: Differential diagnosis of chronic disease of the lungs; x-ray aspects of tuberculosis in all of its phases; pathology and clinical aspects of tuberculosis in all of its phases; management of primary and re-infectious tuberculosis; occupational lung disease—diagnosis and treatment; acute diseases of the lung including atypical pneumonia and minature film method in tuberculosis case finding.

The schedule of towns and dates for each meeting are as follows: The first meeting will be held at the University of Kansas Hospitals in Kansas City on Saturday, August 28; the second meeting in Parsons on Monday, August 30; the third in Wichita on Wednesday, September 1; the fourth in Salina on Thursday, September 2, and the fifth in Emporia on Saturday, September 4. There will be three meetings for each course the first of which will begin at 7:30 p.m. of the date scheduled and last for approximately three hours, the second meeting to begin at 9:00 a.m. of the succeeding day and last until 12:00, with the third or afternoon session to be held from 1:30 p.m. until 4:30 p.m. Each one of the three sessions will last approximately three hours. Additional information will be sent out through bulletins from the Kansas State Board of Health in regard to the exact place of meeting in each town.

KANSAS MATERNAL AND INFANT CARE PLAN PROGRESSES

$171,250 has been appropriated in the State of Kansas to date for the new maternal and infant aid plan for service men's dependents and over 1,800 applications had been received on August 10, according to Dr. Fred Mayes, director of the division of Child Hygiene of the Kansas State Board of Health. It is believed that the total number of cases in Kansas will exceed 2,200 by the end of August.

The plan as accepted under the new act and in use in the state was printed in the June issue of the Journal as well

as the list of service men whose dependents are entitled to participat in the benefits.

On July 12 a report from the Children's Bureau listed thirty-eight states as using the plan and 20,120 cases estimated in the various states. The states in which the plan is in action are as follows: Alabama, Arizona, Arkansas, California, Connecticut, Delaware, Hawaii, District of Columbia, Florida, Idaho, Iowa, Illinois, Indiana, Kansas, Kentucky, Maine, Maryland, Minnesota, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Rhode Island, South Dakota, South Carolina, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming. The states of Ohio, Tennessee, Virginia and the territory of Alaska are also considering the plan at the present time.

NEW ROSTER FOR KANSAS PHYSICIANS

Recently the Kansas State Board of Health has released a new roster of Kansas physicians. When it was found that the Kansas State Board of Medical Registration and Examination could not publish the usual roster, printed semi-annually, due to the great amount of work entailed, Dr. F. C. Beelman, Secretary of the Board of Health decided that publication of such a roster was greatly needed by his department and by many physicians and departments in the state.

Due to the great number of physicians now in service, whose names were listed at their last known Kansas address and are followed in the roster by the letter S, the printing of this year's roster took a great deal more than the usual amount of work and time to complete.

The booklet of eighty-five pages contains the list of members of the Kansas State Board of Medical Registration and Examination, the list of members of the Kansas State Board of Health, a foreword by Dr. Beelman, a copy of G. S. 65-1004a (the Kansas licensure law), a list of states with which Kansas has reciprocity, a list of the health officers in Kansas by counties and towns, and a list of the physicians in Kansas both by counties and alphabetically, giving the license number of each physician.

There were 3,000 copies of the booklet published by the Board of Health for distribution. The cover is unusually attractive, being a silk screen print which was designed in the Board of Health's own department with the design in blue, gold and shades of red-brown.

OFFERS SUGGESTIONS FOR LIMITING SPREAD OF INFANTILE PARALYSIS

Suggestions for limiting the spread of infantile paralysis are contained in a letter from a New York pediatrician to the editor of The Journal of the American Medical Association and published in the July 10 issue of The Journal. The letter says:

"In view of the approaching season for possible poliomyelitis epidemics, it seems wise to summarize possible suggestions for limiting the spread of the disease. These suggestions are founded on present day knowledge, viz.:

"In the presence of the disease in a community:

"1. Avoid the use of any water that is possibly contaminated with sewage either for drinking, swimming or washing utensils. We know that sewage can carry the virus considerable distances and for an appreciable time.

"2. Avoid exhaustion from exertion or chilling. We know that overexertion and chilling during the incubation period tend to augment the oncoming disease.

"3. Avoid injury to the mucous membranes of the nose and throat, such as that resulting from a tonsil operation. We know that poliomyelitis exposures in the early post-tonsillectomy period are liable to result in severe....even fatal—infections, usually of the bulbar type.

"4. Treat every minor illness as a possible case of poliomyelitis, particularly if there is fever, headache and some spasm of the neck, spine and hamstrings. We know that very mild cases of poliomyelitis without recognizable paralysis are much more numerous than paralytic cases. Suspected patients should be kept quiet in bed for several days, and until passed as well by a competent examiner.

"5. Strive for proper sanitary conditions and, in particular, destroy flies and their breeding places. We know that flies can carry the causative virus of poliomyelitis, although it has not yet been proved that they can carry enough to infect human beings.

"6. Avoid unnecessary physical contacts with other people, wash hands carefully before eating, and don't put unclean objects in the mouth. We know that many healthy people carry the virus in their intestines and that for some cases, perhaps most, the port of entry of the infection is the mouth.

"7. Don't prescribe or take drugs or chemicals that are intended to protect against the disease. As yet we know of none that will do this."

Philip M. Stimson, M.D., New York.

COMPENSATION FOR EYE INJURIES*

The following information has been compiled and presented by Mr. Erskine Wyman, Kansas Workmen's Compensation Commissioner of Topeka, Kansas.

Each report of an eye examination which is intended to supply necessary information whereby an industrial visual disability may be evaluated shall comply with the rules and regulations which are hereinafter set out, as far as possible.

There shall be reported all perceptible subjective indications and all demonstrable objective evidences of any recent or remote visual impairment which may pertain to either eye, together with a complete description of the injury. There shall be reported all discernible pathology which in any way adversely affects the industrial efficiency of either eye.

If the examinee has ever worn correction lenses, the dioptric power of those lenses should, if possible, be ascertained and reported. There should also be learned and reported the prescribing refractionist's name, his address, and the date when those correction lenses were prescribed, and the object sought.

The ophthalmic terms, vision, sight, and visual efficiency, are recognized as synonymous designations which may be used interchangeably; likewise, motor field and field of binocular fixation are recognized as synonymic expressions.

* In compiling the rules and procedure for appraisal and evaluation of permanent partial visual efficiency loss as it applies to the administration of the Kansas Workmen's Compensation law, grateful acknowledgement is made for the assistance and advise given by the Committee on Industrial Medicine and the Committee on Conservation of Eye Sight of the Kansas Medical Society and to Dr. Walter L. Small of Kansas City, Missouri. In Kansas, the method of revealing visual acuity determinations without corrective lenses is not a ruling of this commission, but is the law of the state.

METHOD OF EVALUATION

To evaluate correctly the amount of an industrially sustained visual loss, the composite designation "Visual efficiency" shall first be resolved into its several component elements. For the purposes of specific classification, and subsequent evaluation, those several constituent parts of "visual efficiency" shall be further separated into two distinct groups:

(A) Primary and coordinate visual efficiency factors.

(B) Secondary visual efficiency elements.

There are three primary and coordinate visual efficiency factors. They are:

(1) Central visual acuity efficiency.

(2) Visual field efficiency.

(3) Extra-ocular muscle function efficiency.

There are numerous secondary visual efficiency elements. For the purpose of specific identification as well as descriptive accuracy, all interdependent but subordinate elements of vision hereinafter mentioned shall be known as secondary visual efficiency elements. Among those secondary visual efficiency element disabilities are: Scotoma, entropion, ectropion, lagophthalmos, ptosis, metamorphopsia, photophobia, aniseikonia, nystagmus, epiphora, monocular polyopia, heterophoria, asthenopia, faulty color perception, faulty adaptation to dark and to light, faulty or lost depth perception, and imperfect or lost pupillary reactions either to accommodative effort or to alternate exposures to variant gradations of light intensity.

The secondary visual efficiency elements are as intrinsic and as inseparable, integral parts of the comprehensive and composite term visual efficiency as are the primary and coordinate visual efficiency factors.

MAXIMUM AND MINIMUM LIMITS OF THE PRIMARY AND COORDINATE FACTORS OF VISION

In order to determine the various degrees of retained visual efficiency, (A) normal or maximum, and (B) minimum limits, for each primary and coordinate visual efficiency factor, must be established; i.e., the 100 per cent level and the 0 per cent level.

(A) Normal or maximum:

(1) Central Visual Acuity Efficiency: The ability to recognize Snellen letters or characters which subtend a five minute angle, is accepted as the standard whereby visual acuity shall be determined. 20/20 (6/6 metric) Snellen is recognized as the maximum or 100 per cent acuity of distance central vision, and 14/14 Snellen, or Jaeger No. one as the maximum or 100 per cent acuity of near central vision.

(2) Visual Field Efficiency: A visual field having an area which extends from the point of fixation outward eighty-five degrees, down and out eighty-five degrees, down sixty-five degrees, down and in fifty degrees, inward sixty degrees, in and up fifty-five degrees, upward forty-five degrees, and up and out fifty-five degrees, is accepted as the maximum or 100 per cent industrial visual field efficiency.

(3) Extra-ocular Muscle Function Efficiency. A maximum or 100 per cent extra-ocular muscle function efficiency is present only when single binocular vision is present in all parts of the industrial field of binocular fixation, and whenever there can be maintained monocular fixation throughout the entire industrial motor field area with either eye.

(B) Minimum Limits:

The minimum or 0 per cent limit of each of the primary and coordinate visual efficiency factors is established at degree of deficiency which reduces that factor to a state of industrial uselessness.

(1) Central Visual Acuity Efficiency: Experience, experiment and authoritative opinion reveal that a distance central visual acuity of 20/200 Snellen, and a near central visual acuity of 14/140 Snellen, is the threshold of industrial blindness.

(2) Visual Field Efficiency: The minimum limit of industrial field vision is a concentric central contraction of the visual field to five degrees in all eight radial directions from the central point of fixation. This degree of contraction of the industrial visual field reduces that visual field efficiency to zero.

(3) Extra-ocular Muscle Function Efficiency: The minimum limit of industrial extra-ocular muscle function efficiency is established by the presence of diplopia in all parts of the industrial motor field, or by an inability to rotate the eye to any point of fixation within the normal industrial motor field. These conditions constitute zero per cent of industrial extra-ocular muscle function efficiency.

MEASUREMENT OF THE PRIMARY AND COORDINATE VISUAL EFFICIENCY FACTORS AND THE COMPUTATION OF THEIR PARTIAL LOSS

(1) Central Visual Acuity Efficiency.

The maximum, central visual acuity of each of the employee's eyes shall be separately ascertained, without the aid of lenses; also with the aid of properly fitted lenses, both at distances of twenty feet and fourteen inches. The results which have been obtained in that manner shall be recorded in Snellen notations, which are specifically expressive of the distances at which those visual acuity determinations have been made.

Schedule of Percentage Values of the Measurable Range of Quantitative Visual Acuity, Between Normal Industrial Visual Acuity and Industrial Blindness

Visual Acuity at 20 Feet	Visual Acuity at 14 Inches	Jaeger Notation for Near	Percentage of Visual Acuity	Percentage Losos of Visual Acuity
20/20	14/14	1	100.000	0.000
20/25	14/17.5		94.625	5.375
20/30	14/21	2	89.375	10.625
20/35	14/24.5	3	84.375	15.625
20/40	14/28	4	79.500	20.500
20/45	14/31.5	5	75.000	25.000
20/50	14/35	6	70.625	29.375
20/60	14/42	8	62.375	37.625
20/70	14/49	9	55.000	45.000
20/80	14/56	10	48.125	51.875
20/90	14.63		41.750	58.250
20/100	14.70	11	36.125	63.875
20/120	14/84	12	26.125	73.875
20/140	14/98	14	17.750	82.250
20/160	14/112	16	10.750	89.250
20/180	14/126		4.875	95.125
20/200	14/140	17	0.000	100.000

Those recorded Snellen notations shall evidence the employee's certain ability to identify correctly, readily, and consecutively, at least six or more Snellen characters, at the visual acuity level which is thus shown to be the maximum visual acuity of each of the employee's eyes, both with and without the aid of ophthalmic lenses, at the prescribed distances of twenty feet and fourteen inches.

For example: If the employee is able to identify, correctly, readily and consecutively, six or more 20/60 Snellen characters, at a distance of twenty feet, but only three, four

or even five, but not six, of the 20/50 Snellen characters, that employee's distance central visual acuity shall be accepted and recorded as 20/60 Snellen; not 20/50-3 Snellen, or 20/50-2 or 20/50-1 Snellen. Likewise, the employee's near central visual acuity shall be determined, but at a distance of fourteen inches, and recorded in Snellen notations, which are correctly expressive of near visual acuity.

To determine central visual acuity efficiency, twice as much weight shall be assigned to near vision as is given to distance vision.

For example: If the percentage of central visual acuity for distance is seventy-five, and the percentage of central visual acuity for near is fifty-five, the percentage of central visual acuity efficiency will be:

$$\frac{(0.75 \times 1) + (0.55 \times 2)}{3} = \frac{1.85}{3} = 0.6166 \text{ or } 61.66\%$$

The central visual acuity efficiency loss will be 100 per cent minus 61.66 per cent, or 38.34 per cent.

Assuming that there had been neither any temporary total disability nor any temporary total loss of sight; no loss of field vision, no loss of extra-ocular muscle function, nor any secondary visual efficiency element impairments, the number of weeks of compensation due will be 38.34 per cent of 110 weeks, or 42.17 weeks.

(2) Visual Field Efficiency.

The peripheral extent of the field of vision shall be determined by utilizing any standard perimeter and a round white target, under a uniform illumination of not less than five nor more than ten foot candles of light intensity.

The distal or remote terminus of each of the eight principal radii of the field of vision shall be ascertained and expressed in degrees. 500 shall be accepted as the sum of the degrees which indicate the remote extremities of the eight principal radii of a normal or standard industrial field of vision.

If the sum of the degrees which denote the remote extremities of the eight principal radii of a field of vision is found to be only 360, that field of vision is only 360/500 of the size of a normal industrial visual field, or seventy-two per cent industrially efficient, or twenty-eight per cent industrially subnormal.

To determine readily and accurately the percentage value of an industrial field of vision, divide by five the sum of the degrees which indicate the remote extremities of the eight principal radii of the field of vision.

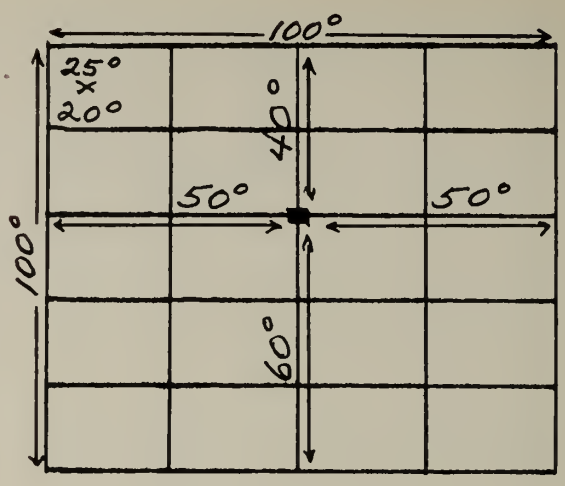
(3) Extra-Ocular Muscle Function Efficiency.

Extra-ocular muscle function shall be measured in all parts of the industrial motor field; authoritatively recognized methods being used for testing.

Traumatic strabismus (squint, heterotropia) may involve one or both eyes. This heterotropia is indicated by the presence of diplopia or by an inability of one or of both eyes to maintain fixation in some part of or in the entire industrial motor field.

When diplopia prevails, that functional disability shall be plotted on the industrial motor field chart. The industrial motor field chart is divided into twenty rectangles; each rectangle being twenty by twenty-five degrees, in size. The partial loss to extra-ocular muscle function, which loss is evidenced by diplopia, is that proportional area of the industrial motor field chart wherein diplopia is demonstrable.

When extra-ocular muscle function efficiency loss cannot be determined by the presence of diplopia, due to excessive degrees of strabismus, or when it occurs in a one-



Industrial Motor Field Chart

eyed person, the amount of impairment must be determined by objective observation. The areas of the industrial motor field in which monocular fixation is not possible shall be plotted on the industrial motor field chart, and the percentage loss of extra-ocular muscle function shall be computed by comparing the nonfixation areas with the entire motor field area. When there is a total loss of single binocular vision, or when one eye is unable to fix on any point within the industrial motor field, the percentage loss in visual efficiency is equivalent to the total loss of the vision of one eye, and when the loss is partial the loss is proportional, based on the total loss of extra-ocular muscle function of one eye, provided the fellow eye has a normal field of fixation. Thus the loss of extra-ocular muscle function is rated as five per cent for each rectangle of the motor field in which there exists diplopia or loss of monocular fixation.

Diplopia or loss of monocular fixation must be irremediable and based on the regulations as hereinafter provided.

MEASUREMENT OF THE SECONDARY VISUAL EFFICIENCY ELEMENTS

Each primary and coordinate visual efficiency factor is readily adaptable to mathematical calculation, but there is no known mathematical formula whereby secondary visual efficiency element values can be numerically evaluated, hence all secondary visual efficiency element disabilities shall be subjected to an analytical appraisal by the examiner through the application of his professional proficiency, his technical judgment and his conception of relative values in rating industrially incurred secondary visual efficiency element disabilities.

The examiner shall submit an appraised percentage value of each existing secondary visual efficiency element disability which has not been taken into account in the evaluation of the primary and coordinate visual efficiency factor disabilities.

COMPUTATION OF COMPENSATION FOR LOSS OF SIGHT EFFICIENCY IN ONE EYE

The industrial visual efficiency of an eye shall be determined as follows: Obtain the product of the computed percentage values of the central visual acuity efficiency, the visual field efficiency, and the extra-ocular muscle function efficiency. If there exist secondary visual efficiency element



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disabilities, the sum of the percentage values of the separate and distinct secondary visual efficiency element disabilities shall be deducted from the percentage value which has been revealed by the product of the three primary visual efficiency factors.

For example: Assume that the retained values of the primary and coordinate visual efficiency factors have been determined to be: Central visual acuity efficiency, eighty per cent, visual field efficiency, 100 per cent, and extraocular muscle function efficiency, eighty per cent. The resultant visual efficiency of the eye, provided there prevail no secondary visual efficiency element disabilities, will be:

$0.80 \times 1.00 + 0.80 = 0.64$ or sixty-four per cent.

Further assume that in addition to the primary and coordinate visual efficiency factor disabilities there are secondary visual efficiency element disabilities of scotoma five per cent, and of entropion three per cent, or a total of eight per cent of secondary visual efficiency element disabilities. The resultant retained visual efficiency of the eye, with all primary and coordinate factors and with all secondary efficiency element disabilities completely accounted for, will be sixty-four per cent less eight per cent, or fifty-six per cent.

The percentage loss of sight is, therefore, 100 per cent less fifty-six per cent, or forty-four per cent.

Assuming that there had been twenty-one weeks of temporary total disability incident to a temporary total loss of sight efficiency, there will be due twenty weeks of compensation at the prescribed compensation rate. One hundred and ten weeks less twenty weeks leaves ninety weeks to be taken into account. Forty-four per cent of ninety weeks is 39.6 weeks of compensation due at the established compensation rate.

COMPUTATION OF INDUSTRIAL VISUAL EFFICIENCY OF THE COORDINATE FUNCTION OF BOTH EYES

The Committee on Visual Economics of the American Medical Association has reported that it is a fact well established by common experience that a permanent visual disability, total or partial, involving both eyes is not equivalent to the sum of the visual efficiency disabilities computed separately for each eye. Hence the necessity for a weighted average when a permanent binocular disability is present. The researches of the committee show that a weighing factor of three applied to the more efficient eye gives an efficiency rating of the individual in substantial agreement with the consensus of technical judgment, such judgment being based on actual reproductions, comparison and relative evaluation of various specific conditions of visual efficiency. Where the visual efficiency of each eye is equal, apply the weighing factor of three to one eye.

If a workman had coincidentally and industrially sustained a permanent, partial visual efficiency loss to each eye; provided that he had not, at the same time, sustained any other permanent, partial industrial disability, the prescribed method of procedure for the computation of the percentage value of that workman's permanent, partial, industrial efficiency loss is exemplified as follows:

If it has been found that the retained, composite, industrial value of the three primary and coordinate visual efficiency factors of a workmen's right eye is fifty-six per cent, after the sum of the percentage values of all secondary visual efficiency element disabilities, which may prevail, shall have been deducted therefrom, and if it has likewise been found that the retained industrial value of that workman's left eye visual efficiency is twenty-five per cent, the retained industrial efficiency of that workman is correctly revealed by the following formula:

$$\frac{(0.56 \times 3) + (0.25 \times 1)}{4} = \frac{1.93}{4} = 0.4825, \text{ or } 48.25\%$$

Since that partially but permanently disabled workman is only 48.25 per cent industrially efficient, obviously he has sustained a permanent, partial industrial efficiency loss of 100 per cent less 48.25 per cent or 51.75 per cent, for which compensation is payable on the basis of a total and permanent disability award of 415 weeks.

The period of temporary total disability shall be deducted from the 415 week permanent total disability period, and compenation shall be paid for the remainder of the 415 week period at the rate found under Section 44-510 (22) of the law, and as further explained in the Procedure and Rulings pamphlet issued by the Commissioner. It must be remembered that the ability to earn is that measured "without" use of corrective lenses, and not "with" corrective lenses. Consequently the rule must be applied that compensation shall be based on the percentage of loss of vision of both eyes, and not on what the injured workman earned before and after the accident, because a case could be conceivable that a workman might earn more after his accident than before; yet he certainly is entitled to compensation if he loses vision in both eyes as a result of injury.

For example: Assume that there was a 51.75 per cent loss of industrial efficiency, and the average weekly wage at the time of the accident was $50.00. If it is further assumed that there were twenty-one weeks of temporary total disability to be taken into account, there will be twenty weeks of compensation payable at the rate of $18.00 per week. There will, therefore, be 415 weeks less twenty weeks, 395 weeks upon which a permanent, partial, general disability shall be computed, on the basis of 51.75 per cent of general disability. 51.75 per cent of $50.00 is $25.88, sixty per cent of $25.88 is $15.53, which will be payable weekly for the remaining 395 weeks.

DEFINITIONS AND DECISIONS

Section 44-510 (c), (15), provides that compensation shall be payable for loss of an eye, loss of sight of an eye, and, (19), permanent partial loss of the sight of an eye, but no method of measuring partial loss of the sight of an eye is provided in the law.

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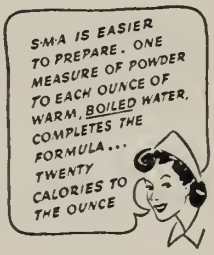
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BASIS FOR COMPENSATION

Total permanent disability of both eyes is identical with permanent total disability of the individual.

Visual efficiency is defined as that degree or percentage of competence of the eye to accomplish its physiologic function.

Complete loss of binocular single vision is equivalent to the loss of one eye.

The reduction in visual acuity to 20/200 Snellen, at a distance of twenty feet, and 14/140 Snellen, at a distance of fourteen inches, is the accepted standard of industrial blindness.

Whenever an enucleation of a workman's eyeball has been performed, if that enucleation had become necessary, either because of an industrially sustained injury or because of an aggravation of a preexisting condition, that workman shall be compensated, in addition to his award for the industrial loss of an eyeball, for the healing period which had been occasioned by that enucleation.

A workman is entitled to payment only for loss of sight, which is a result of an industrially incurred injury to which the law applies, or for an aggravation of a preexisting disability. Thus, in the case of a workman who had a preexisting twenty per cent loss of sight of one eye which, in the course of that workman's usual industrial pursuit and as a result thereof, that preexisting twenty per cent loss of sight had been increased to a sixty per cent loss, that workman would be entitled to compensation only for the difference between twenty per cent and sixty per cent, or forty per cent loss of sight of that additionally impaired eye. However, if a workman who had a pre-employment defective, although usable, sight of an eye, and through his industrial employment had sustained the loss of the remaining sight in that eye, that workman would be entitled to an award for the complete loss of sight of one eye.

If no dependable evidence shall have been produced that a workman had experienced a previous sight deficiency, the sight deficiency of an industrially impaired eye shall be assumed to have been industrially normal prior to the date of the industrial impairment of that eye.

If an injured workman had no previous loss of visual efficiency, the evaluation of industrial visual loss, for the purpose of determining the amount of compensation due, shall be based on visual efficiency findings which have been made without the aid of corrective lenses, except lenses which compensate only for presbyopia (normal old sight), but the employer shall be required to supply corrective lenses as a part of his medical liability. (McCullough v. Southwestern Bell Telephone Company, 155 Kan. 629.)

Where there is complete loss of vision of one eye, due to an industrially incurred injury, and industrial blindness exists in the fellow eye, even if the industrial blindness of the fellow eye is not due to an industrially sustained injury, that more recent and complete industrial loss of the workman's only visually potent eye shall not be rated on the basis of the visual loss of a single eye, but shall be rated on the basis of a permanent total disability. However, a deduction of 110 weeks of compensation shall be made because of the preexisting, total industrial blindness of the fellow eye, and the compensation award shall be computed on the basis of 305 weeks; not 415 weeks. In determining whether or not industrial blindness exists, in that case, the visual disability shall be determined with the aid of properly fitted ophthalmic lenses. If, with the aid of those corrective lenses, it is revealed that the workman is not industrially blind, he shall not be rated on the basis of a permanent total disability, and he shall be compensated only for the permanent, partial visual loss of the more recently and industrially impaired eye.

CANCER STATISTICS IN KANSAS

Dr. F. C. Beelman, Secretary of the Kansas State Board of Health, recently released for publication the following reports on morbidity and mortality of cancer deaths in Kansas. Such information is of great interest to the membership and it is hoped that the cancer education program in the state will result in the stimulation of interest so that in the future these reports can be much more complete.

Cancer Deaths for the Last Six Months
1942

	Male	Female	Total
Buccal Cavity and Pharynx	31	5	36
Digestive Tract	290	253	543
Respiratory System	37	18	55
Uterus	—	103	103
Other Female Genital Organs	—	22	22
Breast	2	106	108
Male Genitourinary Organs	91	—	91
Urinary Organs	35	23	58
Skin	16	14	30
Brain	14	7	21
Other and Unspecified Organs	41	45	86
Total	557	596	1153

Cancer Deaths as to Site of Lesion
1934-1942

	1934	1935	1936	1937	1938	1939	1940	1941	1942
Buccal Cavity and Pharynx	93	90	75	84	91	62	78	58	71
Digestive Tract	1094	1057	1095	1054	1100	1099	1049	1035	1051
Respiratory System	62	58	75	90	94	79	98	102	121
Uterus	202	218	226	211	221	216	222	210	204
Other Female Genital Organs	48	45	44	56	64	55	70	76	55
Breast	204	168	213	227	220	232	201	213	234
Male Genitourinary Organs	207	210	217	204	211	251	183	170	159
Urinary Organs*							87	91	105
Skin	72	61	76	60	55	50	71	55	56
Brain*							38	40	36
Other and Unspecified Organs	188	187	194	182	194	208	116	144	178
Total	2170	2094	2215	2168	2250	2252	2213	2194	2270

*International list of cause of death was changed in 1940. Certain causes of death were added, including cancer of the urinary organs, and brain.

Cancer Cases Reported—Three-Year Period

	1940	1941	1942
January	6	12	9
February	13	16	10
March	10	22	15
April	20	13	10
May	11	32	29
June	22	15	9
July	26	29	16
August	25	22	19
September	22	19	15
October	35	9	14
November	21	15	10
December	27	12	11
Total	238	216	167

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REVIEWING THE ACTIVITIES OF KANSAS MEDICINE 1942-43

War participation has been the outstanding activity of the Society in the past year. Even before the installation of the Kansas Medical Officers Recruiting Board in May, 1941, and after its withdrawal in October, 1942, the Kansas Committee for the Procurement and Assignment of Physicians had been most active in commissioning doctors of medicine in the Armed Forces and in stabilizing civilian medical needs along with the increasing demand for physicians in service. The Kansas Committee was headed by Dr. F. L. Loveland as Chairman and Dr. W. M. Mills as Vice-Chairman. Other Committee members are: Dr. Henry N. Tihen of Wichita, Dr. C. D. Blake of Hays, Dr. C. S. Huffman of Columbus, Dr. N. E. Melencamp of Dodge City, Dr. C. C. Nesselrode of Kansas City, Dr. Alfred O'Donnell of Ellsworth and Dr. Marion Trueheart of Sterling. Those appointed to advisory capacities on the Committee were: Dean H. R. Wahl of the University of Kansas School of Medicine as Medical Education Advisor, Dr. F. C. Beelman of the Kansas State Board of Health as Public Health Advisor and Dr. Charles Rombold of Wichita as Industrial Health Advisor. The Committee in cooperation with the Kansas Medical Officers Recruiting Board under the supervision of Major H. J. Dixon of the Infantry and formerly of Kansas City and Major R. W. VanDeventer, a physician, formerly of Wellington, commissioned 102 physicians and forwarded sixty more names of men to the office of the Surgeon General at Washington, D. C., at the time the office was closed. The Board rejected only sixty-seven men during its stay in Kansas. At the present time there are 568 Kansas physicians now serving in the United States Army, Navy, Air Corps and Marines. This year there has been no quota set for Kansas.

A member of the Wyandotte County Medical Society, Dr. Raymond Cunningham Stiles, 30 years of age was the first medical corps officer to be listed as a war casualty from Kansas. Dr. Stiles, born in Wyandotte County, was killed in an army transport crash on September 3, 1942, near Coamo, Puerto Rico. Since that time reports have been received that another Kansas man, Dr. Elvin Keeton, formerly of Paola, but not practicing in Kansas previous to his enlistment, was killed in action. The Kansas Military Honor Roll was published in the December, 1942, and the January, 1943, issues of the Journal. At the present time there are several additional names to be added to the original lists.

Progress was made on indigent care plans in the State. Some of the counties having organized offices and employed executive secretaries are as follows: The Cowley County Medical Society with offices in Winfield; the Crawford County Medical Society with offices in Pittsburg; the Saline County Medical Society with offices in Salina and the Shawnee County Medical Society with offices in Topeka.

There were twenty-two standing committees in 1942-1943. Three new committees were organized by Dr. Tihen as President, namely: the Committee on Control of Appendicitis, the Committee on Conservation of Hearing and the Committee on Plasma. The name of the Committee on War Work was changed to the Committee on War Participation.

Several new hospitals were established in the State at the various Army air bases and the new Winters General Hospital at Topeka is nearing completion.

The Blue Cross group hospital plan was organized under the Kansas Hospital Service Association, Inc., with offices



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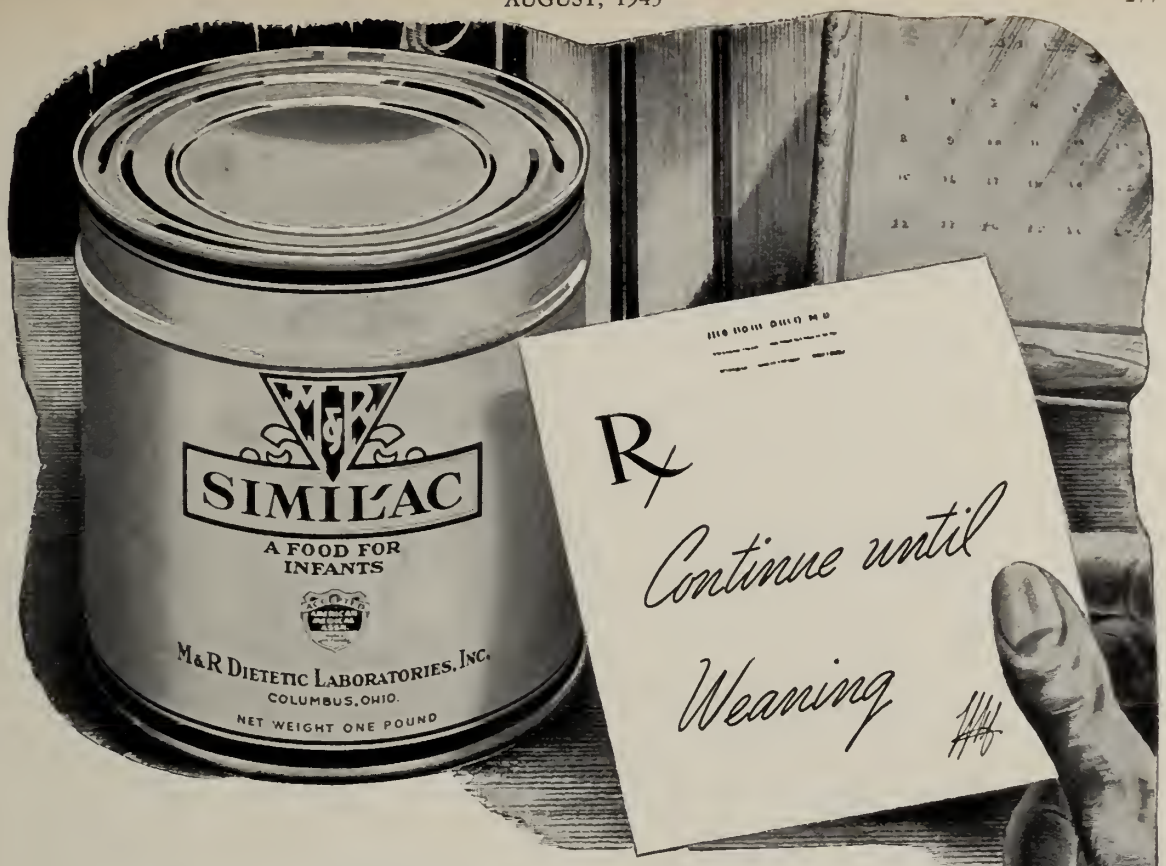
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in Topeka. Passage of the law regarding this by the 1941 session of the Kansas Legislature made this organization possible. Offices were opened on July 1, 1942, with 531 members. At this time more than 14,000 members and forty-three hospitals in the State are affiliated with the group.

The Kansas State Board of Health under the able direction of Dr. F. C. Beelman has had a very busy year. Dr. Regnor M. Sorensen of the United States Public Health Service, formerly of Des Moines, Iowa, was appointed Director of Venereal Disease Control and Dr. R. M. Heilman, also of the United States Public Health Service, formerly of Lyon, Nebraska, was appointed as Director of Industrial Health for the State. The Board of Health most ably handled the Newton Epidemic of September 12th in which 3,000 persons were infected with an intestinal disorder. On investigation it was found thaat the epidemic was spread by the polution of the water supply in the Mexican village. Thirty-five per cent of the population was involved before the epidemic was brought under control by the quick action of the Board of Health.

An Institute for Psychoanalytic Training at Topeka was approved by the American Psychoanalyitc Association and the Topeka organization was granted independent standing as a recognized group.

The resignation of Mr. Clarence G. Munns, Executive Secretary of The Kansas Medical Society since 1934, was accepted, granting Mr. Munns leave for the duration of the war. He is at the present time a Captain in the Air Surgeons office in Washington, D. C. Mr. Robert A.

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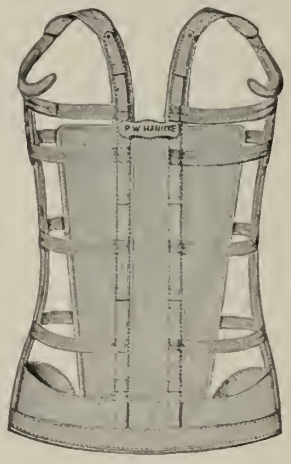
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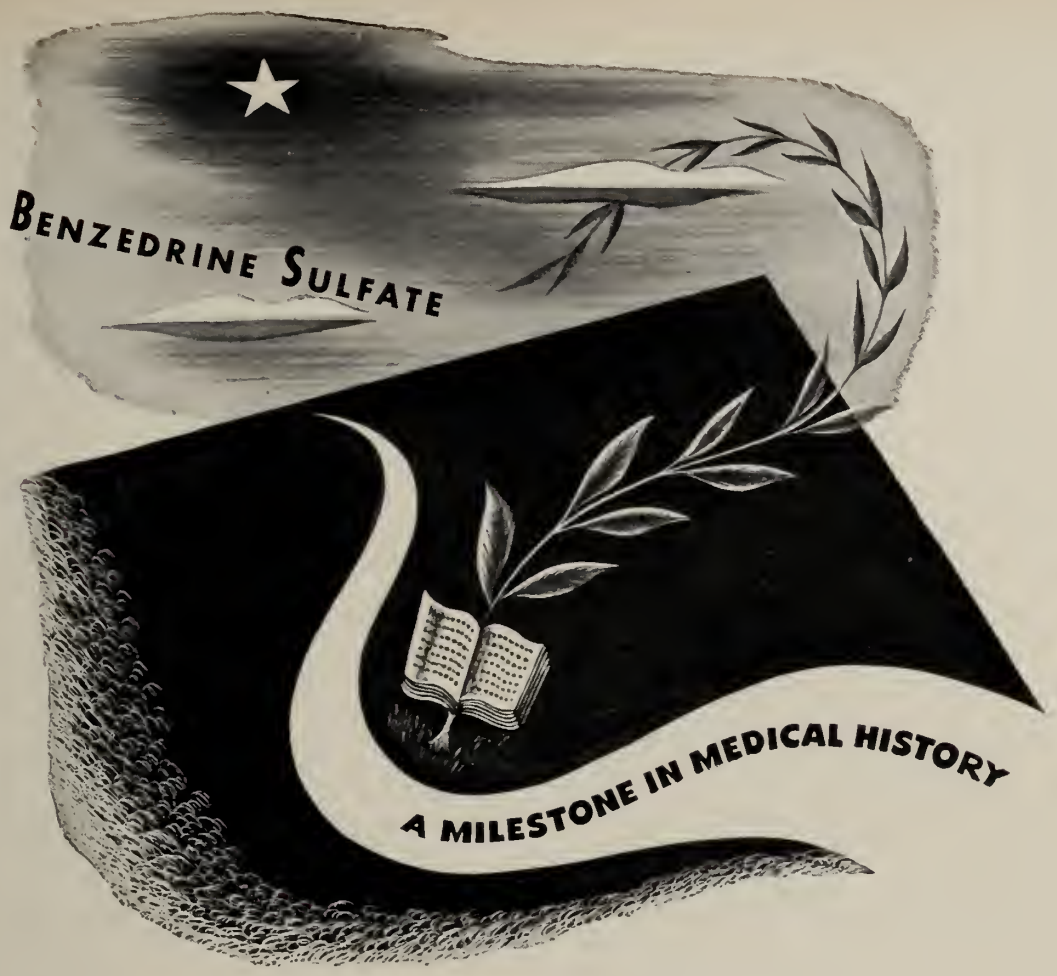
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Brooks of Winfield, formerly secretary of the Winfield Chamber of Commerce, was selected to succeed Mr. Munns and assumed his new duties on October 1st, 1942.

Governor Payne H. Ratner appointed Dr. F. L. Loveland of Topeka and Dr. Hugh A. Hope of Hunter as members of the Kansas State Board of Health and re-appointed Dr. C. E. Joss of Topeka, and Dr. O. L. Cox of Iola. Governor Andrew Schoeppel recently re-appointed Dr. J. L. Lattimore of Topeka as a member of the Board.

Mr. Clarence Beck of Emporia, formerly the Attorney General of the State, was employed as the attorney for the Kansas State Board of Medical Registration and Examination to succeed Mr. Theo F. Varner, formerly of Independence, who is now serving in the Armed Forces. Several new laws regarding the registration of doctors of medicine in Kansas were passed by the 1943 session of the Kansas Legislature, namely: a law releasing physicians in the United States Armed Forces from payment of registration fees during their period of service and a law changing the dates of examination by the Board and reducing the time educational requirements and admitting certain accredited physicians from other schools outside of the United States to practice medicine in the State of Kansas, if qualified by the Board.

The summary of the other various activities of the Legislature affecting the medical profession will be given the report of the Executive Secretary to the House of Delegates. The osteopathic situation was again to the floor in the House of Representatives, although no bills were passed, one measure was brought upon the floor of the House for discussion and the enacting clause was struck out, the bill was killed.

A large number of Society members have held or recently been elected to places of prominence in State and National affairs. The following is a listing of such activities: Dr. W. W. Reed of Topeka was appointed State Supervising Ophthalmologist on November 1, 1942 to succeed Dr. H. L. Kirkpatrick formerly of Topeka who resigned to enter the Armed Forces. Dr. Karl A. Menninger of Topeka was elected as Councilor of the American Psychology Association and President of the American Psychoanalytic Society. Dr. W. M. Mills of Topeka served as Governor of the American College of Surgeons and on the Executive Committee of the Western Surgical Associa-

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** Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245 ** Laryngoscope, 1935, XLV, No. 2, 149-154*

tion. Dr. C. E. Coburn of Kansas City was elected Director of the National Tuberculosis Association and Dr. Charles Lerrigo of Topeka served on the Advisory Committee on Child Hygiene and Guidance of the same organization. Dr. Lerrigo was also elected as President of the Mississippi Valley Tuberculosis Association and Dr. H. L. Hiebert of Topeka was elected a member of the Governing Board of the same organization. Dr. Ernest Seydell of Wichita was elected on the Board of Trustees of the American Medical Association and a member of the Editorial Board of the publication Archives of Otolaryngology. He was also elected as President of the American Otological Society at its May, 1942 meeting. Dr. William C. Menninger of Topeka was elected as Secretary of the Central Neuro-psychiatric Association and Secretary of the American Psychoanalytic Association and Dr. Robert Knight of Topeka was elected as President of the Topeka Psycho-analytic Society. Dr. T. T. Holt of Wichita was elected as Vice-President of the American College of Physicians and Dr. Harold Jones of Winfield was Kansas Representative of the Board of Governors of the same organization. Dr. Lewis G. Allen of Kansas City was elected as Chairman of the Board of Directors of the Radiological Society of North America and Dr. A. K. Owen of Topeka served as Councilor of the American College of Radiology for Kansas. Dr. S. N. Mallison of Augusta was elected President, Dr. Henry Asher of Topeka as Secretary and Dr. F. C. Beelman of Topeka as Treasurer of the Kansas State Public Health Association. Dr. Beelman was also made an Associate Member of the American College of Chest Physicians. Dr. A. L. Ashmore of Wichita was made the Kansas Governor of the American College of Chest Physicians at their annual meeting held in June, 1942. Dr. Paul E. Belknap of Topeka was appointed by the Goveernor of the State of Kansas as the physician member of the Committee on Nutrition. Dr. Ralph J. Hovorka of Emporia became a member of the International College of Surgeons. Dr. Ralph L. Drake of Wichita was made a Diplomate of the American Board of Psychiatry and Neurology, and Dr. W. J. Biermann of Wichita was made a Fellow of the American College of Surgeons. Dr. J. F. Hassig of Kansas City, Secretary of the Kansas State Board of Medical Registration and Examination, was elected as President-Elect of the National Federation of Medical Education and Licensure at its American Congress held in Chicago in February, 1943. Dr. Claude Tucker of Wichita, a Fellow of the American Proctological Society was made one of the fifty members of the Founders' Board of Proctology by the American Board of Surgery. Dr. Samuel J. Crumbine of New York, formerly secretary of the Kansas State Board of Health, and a former member of the Society, was the guest of honor at a dinner held in New York on November 12, honoring the thirty-fifth anniversary of his health drive for the abolition of the disease spreading public drinking cup. Dr. Crumbine promoted many other health campaigns and is at the present time retired from active practice.

The medical profession in the entire country is confronted with the problem of maintaining the health of the civilian population and in furnishing additional physicians for the United States Armed Forces. Every physician on the home front is doing his bit, many members who have retired or planning to retire are again entering active practice, in so far as is physically possible. Kansas medicine stands willing to assist in every way possible this fight to win the war and to maintain the best possible medical care of the people in home and industry, supply additional men for the military forces if needed and to preform any service that may be desired for the good of our country.

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BOOK NOOK

BOOK REVIEWS

VICTORIES OF ARMY MEDICINE — Edgar Erskine Hume, Colonel, Medical Corps, United States Army. Published by the J. B. Lippincott Company, 1943. This timely volume is dedicated to six physicians of the author's name and line and is based on lectures given in the past eighteen months. The point is emphasized that military surgeons were the first contributors to medical science and the book confines itself to work done by career medical officers only and not by those commissioned from civil life in time of war except where the contribution arose directly from the military service.

The portions most interesting to the reviewer are those concerning the Army Medical Library, the Army Medical Museum and the chronological record of advances in medicine made by the Army Medical Corps from the Revolution to Pearl Harbor. The list is impressive enough to thrill every one serving in the Medical Corps.

Colonel Hume's background and experiences qualify him pre-eminently to write a book proving that our medical officers hold their own in comparison with the great medico-military officers of other nations.

W.M.M.

WAR GASES, Their Identification and Decontamination—Morris B. Jacobs, Ph.D., Food, Drug and Insecticide Administration of the United States Department of Agriculture in 1927, Chemist of the Department of Health of the City of New York in 1928, formerly Lieutenant of the United States Chemical Warfare Service Reserve. Published by the Interscience Publishers, Inc. of New York. Priced at $3.00. Dr. Jacobs has written a compact, concise, and yet unexpectedly complete manual for the identification and decontamination of war gases. Primarily intended to serve for the instruction of gas officers, health officers, and air raid wardens, and as a text for the field and laboratory analysis of chemical warfare agents, the book makes no attempt to take up either first aid or medical treatment of gas victims. The numerous tables and diagrams are helpful for quick references, as are the subject and author indices. Numerous references to the literature will aid the student who wishes to pursue the subject more deeply. Although the book is not primarily intended for the physician, the subject is so timely as to have a general appeal, especially for those who may be called upon to treat victims of a gas attack, with the attendant danger of personal contamination.

A.G.

MEDICAL MALPRACTICE—Louis J. Regan, M.D., LL.B. Dr. Regan is a member of the State Bar of California. Published by the C. V. Mosby Company of St. Louis, Missouri, the book is priced at $5.00.

This book is aimed at presenting the subject of malpractice briefly, but with sufficient details to enable the physician to inform himself of his legal obligations to his patients. The factor of prevention, which is so vitally important and which in respect to malpractice has been so much neglected by the medical profession, has received special emphasis. Each section consists of a brief discussion of the problem therein presented, plus extracts from decisions in malpractice cases which serve to illustrate some or all of the points made in the discussion and to set forth

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some of the varying or contrary decisions in regard to particular points. The book is a legal publication and of more interest in value to the lawyer than to the physician.

—K.W.D.

BOOKS RECEIVED

THE KENNY CONCEPT OF INFANTILE PARALYSIS and Its Treatment—John F. Pohl, M.D., Clinical Assistant Professor of Orthopedic Surgery of the University of Minnesota, and Attending Orthopedic Surgeon of the Minneapolis General Hospital in collaboration with Sister Elizabeth Kenny, Honorary Director of the Elizabeth Kenny Clinic of Australia; Honorary Director of the Elizabeth Kenny Institute of Minneapolis; Guest Instructor of the University of Minnesota Medical School; with a foreword by Frank R. Ober, M.D., President of the American Orthopedic Association. Published by the Bruce Publishing Company of Minneapolis and Saint Paul, 1943. The book contains 368 pages, with 114 explanatory photographs and is cloth bound for $5.00.

FLYING MEN AND MEDICINE, The Effects of Flying Upon the Human Body—E. Osmun Barr, M.D., With an introduction by Colonel James H. Defandorf, of the Office of the Chief of the Chemical Warfare Service of Washington, D. C. Published by Funk and Wagnalls Company of New York, the book is priced at $2.50.

SYNOPSIS OF DISEASES OF THE SKIN—Richard L. Sutton, M.D., Emeritus Professor of Dermatology of the University of Kansas School of Medicine and Richard L. Sutton, Jr. M.D., Assistant Professor of Dermatology of the University of Kansas School of Medicine. The book is published by the C. V. Mosby Company of St. Louis, Missouri contains 481 pages, and 413 illustrations and is priced at $5.50.

The popular leaflets "Advice for Mothers" and "Advice for Fathers" have blossomed forth in gay and attractive new editions under new titles and with contents revised and brought up to date.

"Advice for Mothers" is now recognized in its new dress as "For Expectant Mother." It is printed in coral and blue, with an attractive cover design and the caption: "Begin Seeing Your Doctor Before the Third Month." It is a miniature of one of the recent "Family Posters" published by the association. Eight pages—same price as previous edition, fifty cents per 100.

"Advice for Fathers" has become "For Expectant Father." It is also printed in coral and blue, with this caption on the cover: "Be Sure You're Healthy Before You Have Children." Four pages—same price, twenty-five cents per 100. —Briefs, published by the Maternity Center Association.

A SYMPOSIUM OF CLINICAL SYPHILIS — James Kirby Howles, B.S., M.D., M.M.S., Professor of Dermatology and Syphilology and Director of the Department of the Louisiana State University School of Medicine; Senior Visiting Physician of Charity Hospital of Louisiana at New Orleans; Visiting Physician of the French Hospital, Mercy Hospital, Hotel Dieu, Southern Baptist Hospital and Touro Infirmary. Published by the C. V. Mosby Company of St. Louis, 1943. The volume contains 671 pages and is priced at $6.00.

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GYNECOLOGY—Two Weeks Intensive Course starting October 18. Clinical and Diagnostic Courses.

OBSTETRICS—Two Weeks Intensive Course starting October 4.

OPHTHALMOLOGY—Two Weeks Intensive Course starting September 27. Course in Refraction Methods October 11.

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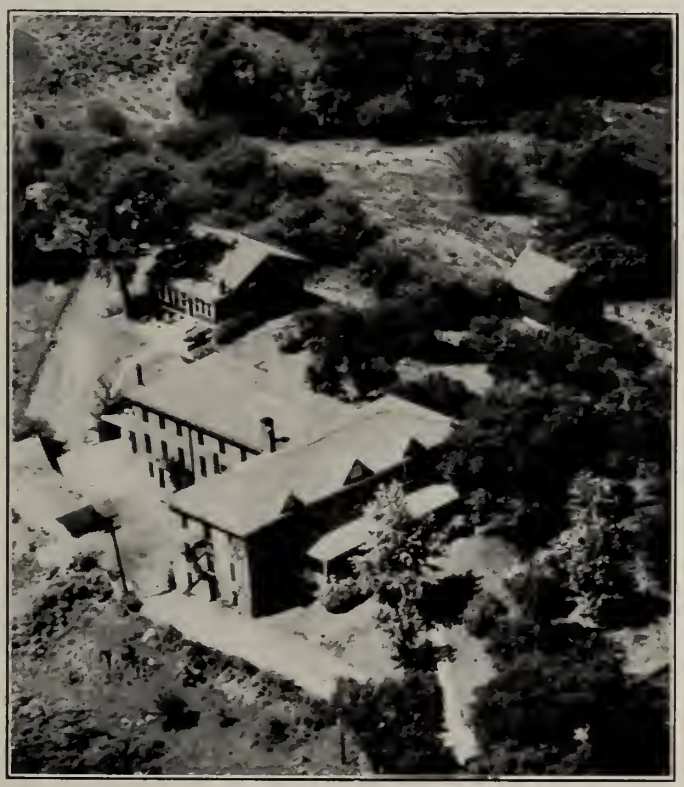
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PRESIDENT'S MESSAGE

Once a week one of our broadcasting stations presents the president of the Wichita Garden Club, Mr. W. J. Van Wormer, Jr. He has a different topic each time, but always emphasizes spraying and hoeing. So each month I wish to stress auxiliary work and war work.

I hope each president with her board, if they have not already done so, is now planning the coming year's work. If it is necessary to economize this year be sure to do away with non-essentials but retain the worthwhile objects that have been built up by your predecessor. This is a time when it takes very careful thinking.

If there are any changes in address from what was printed in the 1942-1943 year book and they were not corrected in the lists sent to the state secretary, Mrs. H. L. Regier, then these corrections should be sent immediately to Mrs. Earl R. Millis, 1517 Minnesota Ave., Kansas City, Kansas.

At the annual meeting of the Women's Auxiliary to the American Medical Association on June 8, 1943, a resolution was adopted to create a committee on War Service for the National Auxiliary and for all state auxiliaries. Mrs. Rollo K. Packard of Chicago, was appointed National chairman. The Kansas State Auxiliary will co-operate with National and I would like for each auxiliary in the state to add this war service committee to their regular committees.

The Bulletin this year will contain a page devoted to auxiliary members who are away from home with their husbands in the armed forces. In this manner members in other states will be informed of those who are in their vicinity and it is suggested that they be invited to share in the Auxiliary activities of the state in which they are temporarily residing.

The Army and Navy needing more nurses. Each month a large number are leaving the hospitals and offices to fill this quota. As doctor's wives we can influence older nurses who have given up nursing to get back into active service, and also encourage young girls as they finish school to take up nursing. It is a worthy service.

Sincerely,
Mrs. Ernest E. Tippin.

AUXILIARY NEWS

At a recent meeting of the Women's Auxiliary to the Wyandotte County Medical Society the following were elected to office for the new year: President, Mrs. John A. Billingsley; Vice-President, Mrs. Eugene Reeves, Jr.; Secretary, Mrs. Galen Tice, and Treasurer, Mrs. A. Huber. The following are the new committee chairmen: Program, Mrs. Donald Medearis; Social and Yearbook, Mrs. F. S. Carey; Public Relations and Health Education, Mrs. J. E. Barker; Legislative, Mrs. LaVerne B. Spake; Speakers Bureau, Mrs. J. F. Hassig; Membership, Mrs. Clarence Weber; Telephone, Mrs. Merle Parrish; Hygeia, Mrs. A. J. Rettenmaier; Press, Publicity and Scrap Book, Mrs. E. J. Grosdidier; Courtesy, Mrs. Hughes W. Day, and Archives and Exhibits, Mrs. W. J. Feehan.

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FOR SALE— Entire ultra-modern medical equipment of the late Dr. Harrison B. Talbot for sale—Address Journal of The Kansas Medical Society, C-03. Mrs. H. B. Talbot, 600 West Eleventh Street, Apt. No. 6, Topeka, Kansas.

FOR SALE—Office equipment of retiring physician engaged in general practice including complete line of instruments, instrument tables (2), sterilizer, anesthesia table, sterile cabinets, irregator stand, centrifuge. Everything in the best of condition. Write C-O—6% the Journal.

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FOR SALE—Entire office equipment, including instruments and files, of Eye Ear, Nose and Throat Specialist. Collections last year over $10,000. Growing town of 20,000. Write Journal of The Kansas Medical Society C-0-4.

The Journal Of
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Volume XLIV SEPTEMBER, 1943 Number 9

ARTIFICIAL RESPIRATION IN POLIOMYELITIS

THE CIVIL AIR PATROL METHOD

Louis K. Zimmer, M.D.

Lawrence, Kansas

I would like to call the attention of the physicians of Kansas to a very useful method of artificial respiration. The current epidemic of poliomyelitis has not yet reached its peak and already there have been several fatal cases of respiratory paralysis recorded. We can anticipate the occurrence of more such cases, and where a Drinker respirator or iron lung is not immediately available, artificial respiration must be carried on. Since this may have to be continued for fairly long periods of time or even while the patient is being transported to an institution where a respirator is available, it might be wise for physicians to familiarize themselves with a method which has certain advantages over the prone pressure or Schafer method of artificial respiration.

This "rocking board" method is better known as the Civil Air Patrol method since all crash crews and first aid squads of this organization are required to become proficient in its use. It can be used in the severely injured, burn cases as well as fractures of ribs and spine where the Schafer method obviously could not be applied. The Civil Air Patrol recently introduced this method and elaborated on it after Lt. Gibbens of the British Navy called attention to the advantages of the original Eve method in an article in the British Medical Journal (December, 1942).

The apparatus consists simply of a wide board or solid support, about eighty by eighty-four by twenty-four to thirty inches, which is balanced on a trestle or sawhorse about thirty-two or thirty-four inches high. On a sawhorse an extra triangular or rounded ridge must be provided so that the board can be rocked up and down freely like a teeter-totter. Two cleats must be fastened to the underside of the support to prevent it from slipping. In an emergency a stretcher or a door slung across a fence or through a rope loop will do until something better can be rigged up. The patient is firmly fastened to the board by the best available means to prevent him from slipping, for example hands and feet can be tied to the stretcher handles. Up and down movement is started by two operators in rhythm, twelve to fifteen complete cycles per minute. When the head is down, the abdominal viscera push the diaphragm up expelling air, when the feet are down the diaphragm is pulled down and air is sucked into the lungs. If the four second count is employed, each up and down stroke should take one second with a one second interval between. This form of artificial respiration can be continued for a long period of time and be-





Fig. I—First part of cycle. The operator on right should continue lifting until the head end almost touches floor. Movement completed in one second. Fig. II—Second part: After interval of one second foot end is depressed and head end elevated until opposite side touches floor. Complete cycle last four to five seconds.

sides the above mentioned advantages, which led to its adoption by the Civil Air Patrol, there are others which are quite important. First of all, the operators don't get tired, since they do not bend over. Each one lifts his end from waist to shoulder height and on the down stroke lets go while the other man takes over. Also, the method is more efficient than the Schafer method as already pointed out by Lt. Gibbens. Dr. Parke Woodard of the Department of Physiology, University of Kansas School of Medicine, is conducting some experiments now on this question. A preliminary test on the conscious subject showed forty per cent greater tidal air volume with this method as compared to the Schafer method. However, more data will have to be compiled before final judgment can be passed.

An outfit such as this can be placed easily on a truck and artificial respiration can be carried on while the patient is being transported to the respirator rather than having the respirator sent to the patient.

On the eve of the Civil War a doctor, Benjamin Morgan Palmer, privately pledged his allegiance to his country. This was spoken in 1860, but the eloquence of his expression remains and today again, as we face a new danger, we may pause to repeat this doctor's love for America and share, more than eighty years later, his faith in and his love for our native land.

"Whatever be the fortunes of America, I accept them for my own. Born upon her soil of a father thus born before me, from an ancestry that occupied it while yet it was a part of England's possessions, she is in every sense my mother. I shall die upon her bosom. She shall know no peril but it is my peril, no conflict but it is my conflict, and no abyss of ruin into which I shall not share her fall. May the Lord God cover her head in her day of battle."—Journal of the Tennessee State Medical Association.

EFFECT OF SULFONAMIDE THERAPY ON THE COMMON COLD*

Lieutenant A. J. Kauvar**

Lieutenant Colonel Frank R. Mount**

It is generally conceded that chemotherapy has no beneficial effect in the treatment of most virus diseases, common upper respiratory infections, or the recently described primary atypical pneumonias. A brief review of the literature failed to reveal any controlled observations on the use of chemotherapy in the common cold. Prompted by the clinical impression that the dangers of sulfonamide therapy far outweighed any advantages that might be obtained from its use in the common upper respiratory infections of unknown etiology, a study was instituted to clarify this point.

The clinical data presented here are based on a study of 127 patients from the Medical Service of the Station Hospital, Fort Riley, Kansas, admitted between November, 1942, and January, 1943. These patients were divided into two groups: (a) Seventy-five cases of acute upper respiratory infections that were treated symptomatically, and without the use of sulfonamides. (b) Fifty-two cases of uncomplicated upper respiratory infections that were treated with one of the sulfonamide drugs in addition to the symptomatic therapy instituted in the first group. The history, clinical and laboratory findings have

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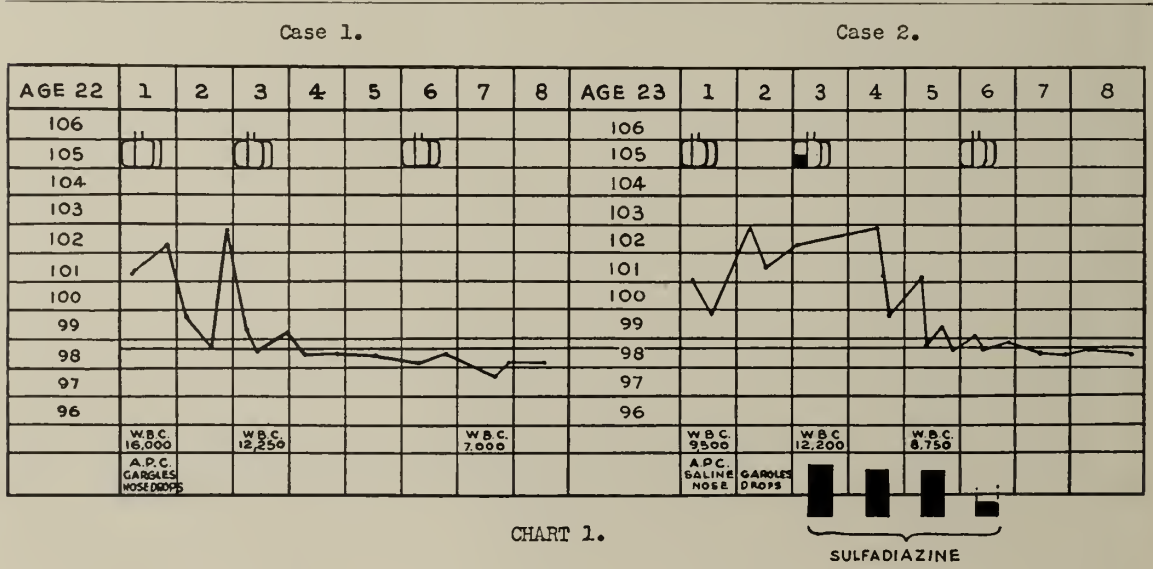


CHART 1.

been studied in an effort to determine whether the use of chemotherapy had any beneficial effect in altering the course of the disease.

A station hospital in an army camp was judged to be ideal for such a study. One is dealing here with men in the same general state of health, in the same age group, and who are subject to uniformity of strict medical control. These patients were sent to the hospital early in the course of their disease and were kept under observation for the entire course of their illness. No attempt was made to segregate these cases into groups on admission into the hospital. On the contrary, these patients as they were admitted to the hospital were distributed to the various wards under different ward physicians. Because of their previous training or experience, certain of the ward officers instituted chemotherapy along with symptomatic therapy in the treatment of the common cold, whereas others treated the patients symptomatically only. These two groups were used as a basis for this report.

The histories of the entire group of 127 patients were similar in all respects — in fact, they were as identical as any series of cases could possibly be. None of them had any complicating factors that could be ascertained, nor were there any unusual findings on physical examination on admission.

A typical history of any of these patients was of a soldier previously in good health who entered the hospital and complained of generalized malaise, soreness of the throat, difficulty in swallowing, coryza and chilly sensations of one to two days' duration. He may have had a slightly productive cough, but no blood-streaked sputum and no actual chill. Physical examination revealed a diffusely inflamed pharynx, but the anterior pillars were usually not reddened. The tonsils may have been moderately enlarged and reddened, but no pus was expressed. Examination of the chest failed to reveal any consolidation. There was no dullness to percussion and the diaphragms moved well. On auscultation, the chest was considered to be clear in every case.

Laboratory data revealed that none of the cases had a white count that was over 12,000. One hundred and ten or 86.8 per cent had white blood counts between 5,000 and 10,000; none of the white blood counts was under 3,000. No anemia was noted. The urine examination on admission was negative in each instance. Bacteriologic examination of material obtained by swabbing the throat failed to reveal any organism which could be considered as a specific etiological agent by reason of its occurrence or predominance. No cultures of hemolytic streptococci were obtained. The predominant organisms were alpha streptococci, pneumococci of the higher types, and staphylococcus albus.

Roentgen examinations of chests were made in twenty of the seventy-five cases that received no chemotherapy (26.6 per cent) and were negative in all instances. Roentgen examinations of chests were made in eighteen of the fifty-two cases that received sulfonamide therapy (34.2 per cent) and all were negative.

Thus it may be seen that we are dealing with a comparable group of patients—all having the characteristic symptoms of the common cold, and differing only in the type of therapy that was administered.

All of the seventy-five patients comprising the first group were treated symptomatically. Aspirin, aspirin-phenacetin-codeine capsules, saline gargles, nose drops, steam inhalations, cough syrups were used to some extent in all the cases. Of the fifty-two cases comprising the second group, all received some of the supportive therapy that was instituted in the first group. In addition, thirty-two (69.2 per cent) received sulfathiazole, fifteen (28.5 per cent) received sulfadiazine and one (1.9 per cent received sulfanilamide. The usual dosage was 2.0 grams initially, 2.0 grams in two hours and 1.0 gram every four hours thereafter. The length of time that the drug was administered varied between three and eight days.

ANALYSIS OF DATA

Of the seventy-five cases in the first group treated symptomatically the oldest patient was forty-three years old, and the youngest patient eighteen years old. The average age was 27.6 years. The average length of army service was 5.3 months. The highest temperature recorded in this group was 103.8 degrees with an average temperature elevation of 101.2 degrees. The average number of days in the hospital was 5.26 days varying between three and nine days.

These figures are comparable to those of the second group comprising fifty-two cases of uncomplicated upper respiratory infections treated with chemotherapy. The oldest patient in this group was forty-four years old, and the youngest nineteen years old. The average age was 28.2 years. The average length of army service was 2.9 months. The highest temperature recorded in this group was 104.2 degrees with an average temperature elevation of 101.8 degrees. The average number of days spent in the hospital was 5.01 days varying between three and twelve days. (Table I.)

There was no complication in either group secondary to the initial infection and there was no seri-

ous reaction following the administration of chemotherapy. However, two patients developed mild toxic erythema secondary to the administration of chemotherapy and one patient had albuminuria which cleared subsequent to the discontinuance of the drug.

DISCUSSION

The material in this paper is presented in an effort to shed some light on the routine use of chemotherapy in the common cold, either in the hope of shortening the course of the disease itself or of preventing complications.

It is apparent from the cases studied here that the use of chemotherapy as a routine in uncomplicated respiratory infections had no effect in altering the course of the disease. The hospital stay of the patients receiving chemotherapy was not shortened to any appreciable extent. The patients who did not receive chemotherapy recovered just as promptly as did those who received sulfonamide compounds and there was no evidence that the number of complications was increased in this group.

If chemotherapy has no effect in shortening the course of the disease or in preventing complications, there would seem to be no justification for its use in the common cold. Although we were extremely fortunate in not having had serious complications secondary to the sulfonamide administration, mild reactions were present in three cases. Complications secondary to chemotherapy administration are probably more frequent than the complications that may develop in the untreated common cold. It has been estimated that one in 1,000 patients with colds will develop pneumonia[1], whereas the complication rate secondary to sulfonamide administration is much greater[2]. Furthermore, the complications secondary to sulfonamide administration in a sensitive[6] individual may be extremely serious as has been shown many times[2 3 5]. Thus the complications of sulfonamide therapy may not only be more serious than the complications of the common cold, but also more frequent.

Furthermore, there is increasing evidence to the effect that numerous pathogenic bacteria may acquire a tolerance or resistance to one or more of the sulfonamide compounds. They then become able to multiply in the presence of the usual bacteriostatic concentration of these agents. Consequently, sulfonamide-fast infections often do not yield to many times the usually sucessful therapeutic doses of sulfanilamide, sulfathiazole, or sulfadiazine. Generally speaking, this acquired sulfonamide fastness is believed to be due to increased production of sulfonamide inhibitors by the organisms[7 8 10].

This immediately suggests that there may come about the selective propagation of drug resistant bacteria. It is conceivable that the dissemination of these resistant organisms by carriers will ultimately curtail the value of sulfonamide therapy[10].

In addition, there is a growing body of evidence, clinical and experimental, indicating that the number of toxic reactions following sulfonamide therapy is much greater in those individuals that have previously received one of the sulfonamides. Consequently, the use of chemotherapy in a trivial case may sensitize the individual so that its use is contraindicated in a more serious illness where its use is urgently needed.

Spink, in an article entitled "The Use and Abuse of Chemotherapy," states that the indiscriminate use of sulfonamides in mild respiratory infections of unknown etiology has given questionable therapeutic results and has provoked many instances of hypersensitivity to these compounds[8].

It would seem wiser to reserve the use of chemotherapy for those cases where a proved therapeutic indication exists. It should not be withheld in those severe upper respiratory cases where fever and symptoms show a tendency to increase along with increasing leukocytosis and evidence of spread of the infection into the parenchyma of the lung, by either physical or roentgen examination.

The following two cases will serve to illustrate the proper use of sulfonamides in the treatment of the common upper respiratory infection.

The history of each of these cases was identical in that each had symptoms of mild upper respiratory infections of one day's duration. Physical examination at the time of admission revealed a mildly injected throat in both instances but no enlargement of the tonsils or reddening of the anterior pillars of the throat. The lungs were clear at the time of the initial examination.

The initial white blood count in the first case was 16,000 with eighty-three neutrophiles, but because this was judged to be a case of the common upper respiratory infection without evidence of spread, symptomatic therapy was instituted without the use of sulfonamides. During the next few days, there was no evidence of pulmonary extension, and the patient improved rapidly. His white blood count had dropped to 12,250 on the third hospital day, and was 7,500 on the seventh hospital day when the patient was discharged to duty.

Contrasted with this case, the second patient had an initial white blood count on admission of 9,500, and in fact did not appear as ill as did the first patient. By the third day however, it was evident that the patient was not improving. Physical examination of the chest at that time revealed increased breath sounds over the righ lobe posteriorly, and fine

rales were present in that area. The white blood count at that time was 12,200. These findings indicated the possibility of extension of the infection into the parenchyma of the lungs. This was confirmed by roentgen examination. Consequently, sulfadiazine was administered orally, 2.0 grams initially, 2.0 grams at the end of the first hour and then 1.0 gram every four hours day and night. The infection did not spread any further, and after four days of sulfonamide therapy, the physical and roentgen examinations of the lungs were again negative and the patient's convalescence was uneventful.

If a sulfonamide had been administered to the first patient early in the course of the disease, the credit for the patient's recovery would have been given to its use, whereas, it was obvious that the patient would have recovered promptly without it. In the second case, prompt use of sulfonamides probably prevented the progression of a severe complication of a mild upper respiratory infection.

It cannot be too strongly emphasized that accurate and careful observation by an alert physician should enable him to choose those cases of upper respiratory infection in which chemotherapy will be required. To administer sulfonamides routinely as a substitute for careful observation of the patient is a sad commentary on clinical practice.

CONCLUSIONS

1. A study of 127 patients with upper respiratory infections of unknown etiology was made. There were seventy-five cases that were treated symptomatically and fifty-two comparable cases that were in addition treated with sulfonamides.

2. In this study, there was no evidence that the use of chemotherapy influenced the course of the disease or prevented complications.

3. Complications secondary to chemotherapy administration tend to be more frequent and more severe than those following the usual upper respiratory infection. Use of chemotherapy in a trivial case may sensitize the individual so that its subsequent use is contraindicated in a more serious illness where it is urgently needed.

4. Careful clinical observation should enable the physician to select those upper respiratory infections which require sulfonamide administration.

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Three hundred and fifty million work days lost annually through illness of the gainfully employed is our country's discreditable record. At a wage of five dollars a day this means a $1,750,000,000 yearly deficit in labor and production. Assuming that half of this is due to preventable disease we could build a dozen battleships in the time saved by full use of known preventive measures.

In working days lost per case, tuberculosis heads the list of unnecessary disabilities. This national loss is not due alone to doctors, nor the public health service, nor the ignorance and carelessness of the people themselves. The blame belongs to all three. The fervor of patriotism sweeping the country keeps our eyes fixed overseas. We are united in the will to annihilate despotism and reestablish freedom for all nations. This is our duty, but we must not forget the treacherous enemy within our own boundaries. Tuberculosis, in collusion with its fellow fifth columnists, is impeding victory by a campaign of sabotage behind the lines.

The armed forces have foreseen the menace of tuberculosis in the ranks and are taking active measures to combat it. Industry has awakened to the threat but is still floundering in its effort to thwart it. The medical profession is only half alive to its opportunities for patriotic service. Right now is the moment to stand by the men who make the guns in an all-out fight to eradicate this leading saboteur of victory.—Kendall Emerson, M.D., Journal Lancet.

TABLE 1

Analysis of Data

	No. of Pts.	Oldest Pt.	Yungest Pt.	Average Age	Average Length Army Service	Highest Temp.	Average Temp.	Average No. of Days in Hospital
Group I	75	43	18	27.6	5.3 months	103.8	101.2	5.26
Group II	52	44	19	28.2	2.92 months	104.2	101.8	5.01

Group I—Those cases of upper respiratory infection that received symptomatic therapy only.

Group II—Those cases of upper respiratory infection that received sulfonamide therapy in addition to the symptomatic therapy.

FUNDAMENTALS OF PSYCHIATRY X

THE PERSONALITY STRUCTURE

William C. Menninger, M.D.

Topeka, Kansas

The personality cannot be dissected, unfortunately, and displayed in parts like the brain. In fact it cannot be even portrayed in diagrammatic sketches with out the danger of over-simplification and gross distortion. Our conception of the interrelated parts of the personality must always remain theoretical, but like the atomic theory, it is well substantiated by evidence and is essential to some understanding of the ways in which the personality functions.

It seems desirable to repeat certain points about the personality discussed in previous installments of this series. The term is used by the psychiatrist to refer to the sum total of the individual's characteristics and reactions, both physical and psychological. It is not synonomous with "mind" but is inclusive of the mind. In addition it includes the physical structure, the body, the responses of every part of the body, the intellectual and emotional make-up, and thus refers to the individual as a whole. It might be defined as all that a person has been, all that he is, and all that he hopes to be. Consequently, when we consider its "parts," these parts are regarded as interrelated functional units, rather than as anatomical or physical units. They are forces rather than material.

One approach to the understanding of the personality structure is the consideration of the levels of consciousness. Although merely descriptive, the personality can be divided into three levels: consciousness, preconsciousness and unconsciousness. These may be thought of as zones, perhaps comparable to daylight, twilight, and darkness. Consciousness is closest to the surface, adjacent to the external world. Below the conscious zone and fading imperceptibly without a sharp boundary is a layer of preconsciousness. In this area (a transition zone from consciousness to unconsciousness) repressed ideas pass enroute to unconsciousness. Names, events, ideas fade from consciousness. Sometimes these are recalled easily; sometimes we know the name well but cannot recall it from this area even with effort. And through the preconscious zone must come the impulse from our unconscious, that deepest layer of the personality which (as was explained in the last installment) is beyond accessibility to the conscious part of the personality by any ordinary means of contact.

PSYCHOANALYTIC CONCEPT OF PERSONALITY STRUCTURE

In order to explain human emotions and thought and behavior, the psychoanalytic school divides these conscious and unconscious regions into three functional and interrelated systems, each of which has certain characteristics and functions, and each of which is dependent to some degree on the others—the Id, the Ego, and the Super-ego. The primitive unconscious Id (the infantile part of the person) can be described as saying, "It wants." The phrase is stated in the third person using "It" because the Id includes that part of all of us which often we would rather not claim. In the commonly expressed phrase, "something within me made me do it," the "something" refers to this "Id." The Id "wants" because it represents that part of every person that is selfish, that makes demands, that gives rise to our spontaneous, uncontrolled and primitive behavior and wishes. In response to the Id's request (whatever it may be) the conscious part of the personality—the Ego—answers "I will," or "I will not." The Ego thus represents rationality, the judgment and the will power that decides whether to or not to accede to the demands of the Id. Then the third part of the personality—the Super-ego—speaks up as a kind of conscience or referee to say, "You must not." The Super-ego is the doubter, the skeptic, the critic; it is that portion of the personality that always denies or forbids or disapproves.

Such a concept of the personality as that depicted in this three-part system must be recognized as a formula—a formula to give meaning and significance to the internal struggles of the individual. It is not an anatomic differentiation, and to date we do not know enough to locate the chief functions of the Id, Ego, and Super-ego in any specific parts of the brain or its physical structure.

THE ID

The Id, a term which literally means "It," is that portion of the personality which constitutes most of the unconscious region. It constitutes all of the personality at birth, and consequently contains all of the characteristics inherited from the race. The Id remains primitive and unrefined throughout life. It is animal in nature, and is that part of the individual referred to popularly as "the animal in man." It has no regard for morals; it never learns or acquires what we think of as intelligence, and it is fearless. It never "grows up"; it changes little from birth to adulthood except through the additions of certain experiences which the conscious part of the individual refuses to keep in its own house, and so forces into the domain of the Id. Its only rule of existence

is to seek pleasure and avoid pain, regardless of consequences.

Its function, if we may describe it as such, is to supply the psychic energy which the person uses in life, the will to live. It is the source of tremendous power, power expressed through the instinctual and primitive drives to love and to hate, known also as the erotic and the aggressive drives which correspond to the constructive and destructive impulses. It is the source of all emotion. When the emotion is for some reason or other blocked in its outlet, tension arises; thus, the Id is concerned in the origin and source of all tension.

THE EGO

The Ego makes up the bulk of the personality which we refer to as consciousness. Most of it is conscious and it represents the thinking, knowing, and feeling part of the person. All that any individual knows or remembers is included in this part of the psyche. While we cannot ascribe size to any of these parts of the personality, we do recognize that the Ego begins to develop at birth, in contrast to the Id which is well developed at birth. As one learns from experience and gains in knowledge it must be assumed that the Ego expands, and that it grows stronger as long as mental growth continues.

The Ego has numerous functions. It is the intermediary between the world (the environment outside the individual) and the inner demands, wishes, and desires which originate in the Id. Thus, its first function is to make the primitive drives of the Id conform to the demands of reality. Its guiding rule (so long as it is healthy) is to abide by and to accept reality. It has the function of organizing in a coherent fashion the mental processes. It has the responsibility of obtaining gratification and satisfaction from the environment. It must function to control and govern the crude though superior strength of the impulses which come from the deep unconscious—the Id. It must mold these so that they are acceptable to the world outside the personality. It must prohibit the direct expression of certain of the primitive desires because they are self-destructive of the environment. For instance, a diabetic may crave intensely sweets but holds the craving in check. A man may recognize sexual interest and desires toward his friend's wife, but he suppresses them. In addition to the conscious volitional control, the Ego has the function of repressing certain of the primitive desires, an unconscious control. In this process the Ego refuses to recognize the desire; it denies the existence of the desire. It excludes it from its own domain and pushes it back by this process of "repression" into the domain of the Id. The Ego controls all voluntary motor function, whether it be speaking or walking or driving a car. It goes to sleep but it still censors any thought processes that go on, and so one's nocturnal mental activities are forced to express themselves in bizarre and distorted forms called dreams.

THE SUPER-EGO

The Super-ego, the third part of the personality, is largely unconscious. It begins to develop in the individual about the fourth or fifth year as a partial solution of the Oedipus situation. As a result of the Oedipus conflict, the little child borrows strength from his parents through identification with them and sets up an inhibiting force, a police force, within himself. This results in the formation of a kind of conscience, a part of the personality that keeps saying to the Ego "You mustn't." It is the permanent expression in each individual of those early influences of parents and teachers.

Thus the Super-ego can be considered as an unconscious conscience, a critic, who stands on the sidelines watching how the conscious Ego handles the primitive demands and strivings from the Id. When the Ego makes a poor decision, or at least one with which the conscience cannot agree, the Super-ego criticizes and condemns the Ego. When the normal individual wrongs or hurts another person, particularly if he is a friend, he develops a sense of remorse in proportion to his understanding of the degree or extent of the aggression. In such an event the Ego feels guilty and seeks punishment. The person is quite conscious of this sense of guilt and feels the need to make restitution. In many instances, he overevaluates the wrong and his Super-ego forces him to make excessive efforts toward restitution. In some kinds of mental illness this sense of guilt is created in a portion of the Ego which is not conscious (all the Ego is not conscious). To neutralize this unconscious guilt the individual may unintentionally (unconsciously) arrange various kinds of failure for himself, for in every instance the Super-ego demands that the Ego be punished.

THE INTERRELATIONSHIPS

A knowledge of the interrelationships of these three parts or systems within the personality is important in understanding human behavior. When the equilibrium between these three parts is disturbed, maladjustment is the result, and the expression of the maladjustment is always in the form of symptoms.

These three portions have been compared to the three divisions of the American government. The Id is the legislative branch, the source of power; the Ego is the executive division, the group which utilizes the power given by the legislative division (the

Id); the judicial division is the Super-ego, the critic, the judge, and the condemner. The populace represents the external world which makes demands which ultimately determine the status of all three divisions.

Thus, we can see that the Ego serves three masters, Id, the Super-ego and Reality, (just as the executive division must give expression to the laws of the legislators, the dictates of the judges, and serve the general populace). The Ego must conform to one master in the form of reality, that is, the external world. Sometimes reality makes demands which the Ego cannot accept, presents situations to which it cannot adjust. Thus, we have seen that the precipitating factors of mental illness disturb the internal equilibrium, and the failure to remain loyal to reality results in the development of falsification—delusions, hallucinations, and illusions.

The Ego serves a second master in the Id with its superior strength and impulses which demand expression. If the Ego is sufficiently strong it either holds these demands and impulses in check or modifies them to some form of expression which is socially approved. On the other hand, if the Ego is weak it may permit certain of these primitive impulses to gain direct expression, as we see in the psychoses, e.g., exposure of the person, masturbation practiced openly, playing with feces. In other instances, the Ego remains loyal to reality but the primitive wish puts on a masquerade and so disguises itself to gain expression without the Ego recognizing it as the original wish. The Super-ego does recognize the wish for what it is, however, because it is better acquainted with the struggle between the Id and the Ego. When such wishes gain disguised expression they appear as neurotic symptoms, and every neurotic symptom represents a distorted expression of a primitive desire, of a forbidden desire, but because this desire can gain expression only with the condemnation of the Super-ego, the personality must suffer. The Super-ego demands punishment of the Ego and this is given through the pain or the distress by the symptoms.

Last, the Ego serves the Super-ego as its third master. The Super-ego dominates the Ego and is critical of the way the Ego handles the Id impulses. It is an inner judge, in part an unconscious judge, and so the impulse, the guilt, and the method of punishment may all be unconscious.

The equilbrium of the Ego is threatened continuously from all sides—from external reality, from the tremendously powerful impulses from the Id, and from the criticism of the Super-ego. When the Ego weakens from any of these threats the individual responds with a symptom we call anxiety. To avoid anxiety the Ego develops certain devices we call dynamisms, or mechanisms, which serve to maintain the equilibrium between these three portions of the personality. They serve as a medium of expression between the Id and external reality. These mechanisms are a necessary part of the functional equipment of the Ego of every person, and they constitute one of the most widely accepted portions of the psychoanalytic theory.

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To parallel the policy of the War Department not to admit to the army any one unable to pass a rigid physical examination or whose age is over sixty, the following men should have been either at once discharged or not accepted for service by their respective governments.

Moses—Over age, eighty when he took command.
Saul—Insane.
Alexander—Inebriety and temper.
Charlemagne—Over age in last campaign.
Mohammed—Catalepsy.
Djengis Khan—Paranoia.
Richard III—Hunchback.
William of Orange—Chronic asthma, "an asthmatic skeleton."
Oliver Cromwell—Precancer of skin.
Charles II—Tuberculosis.
Frederick the Great—Kyphosis and suicide obsession.
Duke of Wellington—Under weight.
Marshall Blucher—Over age, was 73 at Waterloo.
Julius Caesar—Epilepsy.
Napoleon Bonaparte—Chronic stomach ulcer and under size.
George Washington—No opposing molars.
Columbus—Over age last voyages.
Lord Cleve—Mental instability, suicide complex.
Garabaldi—Over age in Franco-Prussian war.
General Shafter—Over weight and unable to ride a horse.
Ulysses S. Grant—Inebriety, once forced to resign for same.
W. T. Sherman—Nervous, thought insane by some.
Mike Lawler—Over weight, hero of assault at Vicksburg.
Stonewall Jackson—Paralysis of hand from gun shot.
General Hancock—Gun shot of leg, later amputated.
Philip Kearney—Lost arm in Mexican war—in Civil War.
Benjamin Butler—Nearly blind in one eye.
Kaiser William—Birth palsy and atrophy one arm.
Sergeant York—Conscientious objector.
Joseph Wheeler—Over age at Spanish-American war.
Abraham Lincoln—Disproportion of weight and height.
Horatio Nelson—Loss of one arm and an eye.
—R. CADWALLADER in Journal of the American Medical Association.

Do not forget that of all the countless remedies, rest, alone, has stood the test of time.—Gerald B. Webb, M.D.

President's Page

To the members of the Kansas Medical Society:

There is a great need for a closer feeling of cooperation between physicians and hospitals. The hospitals can aid greatly in the situation by helping to conserve the physicians time, in avoiding unnecessary calls and services. On the other hand, the physicians must remember that all hospitals are operating under handicaps that will not permit them, at times, to render as quick service as in pre-war times.

With most hospitals, the nursing situation is acute and serious. The thinking physician will not make an excessive number of demands upon nurses in hospitals, realizing that they are taxed to the limit of their ability.

In other departments of the hospitals the problems are likewise difficult. At times, certain drugs are extremely hard to obtain, laboratory and x-ray technicians are scarce, the food situation is not what the administrators would desire. Hospitals and their various departments, nurses and technicians are too closely allied to the medical profession, for us to fail to cooperate in every possible way.

Sincerely,

J. L. Lattimore M.D.

President, The Kansas Medical Society

EDITORIAL

TOTAL BUREAUCRACY FOR MEDICINE

Much has been written of the Wagner Bill, and as one reads, the bill stands out as the most vicious piece of legislation ever to be proposed in Congress. There is nothing in the proposed act to better medical and hospital care and the only emphasis is on distribution of such services. Practically all citizens, well to do and those in modest income brackets, who would never need this governmental assistance are included simply because this is another way to grab their money in an amount far beyond any conceivable benefit to them.

All citizens employed by others are forced without option in to a payroll tax and payroll deductions amounting to 12 per cent for the social security program which includes medical and hospitalization benefits. Physicians and hospitals are supposed to have the option of refusing to enter the medical program but it will be impossible for either to exist outside since all the patients will be wards of the government.

This bill makes the surgeon general of the Public Health Service the medical czar of the people of the United States with complete control of the medical profession and hospitals, medical education and research. Doubtless this will result in the elimination of a large number of voluntary hospitals and deter the more desirable element of our youth from embarking on a medical career.

There is good actuarial evidence that the proposed program when in full operation, will cost 20 per cent of the payroll of employees and self employed. Three billion dollars will be allocated to medical and hospital care at the start but one-fifth or six hundred million will be necessary to pay the costs of administration, an entirely new expense added to medical care. More bureaucrats—another bureau.

The system of old age annuities and unemployment compensation is still in a period of experiment and appraisal as to costs and benefits. Additional social security can be won by the eorts of the individual. Security as well as social security is dependent on the fullest possible employment. Let the government prevent mass unemployment by private enterprise, prevent accidents and disease through the Public Health Service instead of paying people to be sick and unemployed.

Let us rather combat these things by education, thrift and some reasonable form of insurance and continue our public assistance to the needy.

GEORGE M. GRAY INJURED

Recenly word has been received in the central office that the guardian of the finances of the Kansas Medical Society had met with an accident. Dr. George Gray, 87 years young, Treasurer of the Kansas Medical Society has suffered a fracture of the right hip and other injuries in a fall from the rock wall surrounding his home at 1305 Hoel Parkway in Kansas City. Dr. Gray was watering the flowers in the garden when he fell we have been told, not climbing the wall.

For years Dr. Gray has put to shame many of the younger doctors in the state in civic, professional and society activities. His accident comes as a great shock to the membership and the central office, where his help was always willingly available for advise, aid and general information on medical, organization and financial matters.

According to previous records in the office: George Morris (preferably "M") Gray was born in Waukegan, Illinois, on March 4, 1856, and two years later his father emigrated to Kansas where they lived on a fruit farm near Quindaro. He worked first on the farm and then secured employment at a drug store located at 817 Main Street in Kansas City where he decided he would study medicine. In 1879 he was graduated from the Kansas City Medical College and from the Bellevue Hospital Medical College in New York in 1880. He was married to Caroline Harlan, his childhood sweetheart, on November 23, 1881.

It would take many pages of the Journal to recite in detail the accomplishments of Dr. George M. Gray but in brief we will list a few: assisted in the founding of the St. Margaret's Hospital in Kansas City in 1887, is past president of the Kansas Medical Society, also past president of the Wyandotte County Medical Society and the Kansas City Academy of Medicine. He is a member of the Western Surgical Association, of the Kansas City Southwest Clinical Society, and a fellow of the American Medical Society and the American College of Surgeons. He has served as mayor of Kansas City, Kansas, as county physician and coroner as well as president of the Chamber of Commerce. He has been a lecturer on anatomy at the Kansas City Medical College and professor of clinical surgery of the University of Kansas School of Medicine of which he is now Professor Emeritus. His professional methods have been quoted in text books on surgery and it has been his policy through his active professional life to give

one-fourth of his time to charity. During World War I he received acknowledgment from the Kansas Council of National Defense for his valuable assistance to the war effort.

He has been several times honor guest at meetings commemorating his fifty years in practice.

Dr. Gray has kept the wheel of Kansas medicine steady in its path and served with distinction in every position held during his many years of service. He is without doubt the "Dean" of the Kansas profession.

MEDICAL SCHOOL

ERYTHROLEUKEMIA

Ralph H. Major, M.D.*

C. J. Weber, M.D.*

Kansas City, Kansas

A relationship between polycythemia and leukemia has been suspected since the observation of Türck, who, in 1904, described four cases of polycythemia associated with marked leukocytosis. One of his patients showed a leukocytosis of 33,800 with myelocytes, a red cell count of 9,965,000 and a hemoglobin of 140 per cent. Blumenthal in 1907 described a patient who showed a red cell count of 11,450,000 with a leukocytosis of 16,300, thirty-six per cent of the cells being myelocytes. He thought it was a new disease and gave it the name "polycythémie myélogène." In 1908 both Rosin and Nicola described cases in which polycythemia was followed by leukemia. Similar cases have since been reported by Weber, Pendergrass and Pancoast, Minot and Buckman, Herxheimer, McAlpin, Brieger and Forschbach, Daniels and v. Buchem, Nicola, and Émile-Weil and Cahen.

The reverse picture, in which a patient with leukemia develops the picture of polycythemia vera, may have been described by Winter in 1908. Winter's patient was diagnosed in 1904 as myelogenous leukemia, showing at that time 4,800,000 red blood cells, 22,600 leukocytes with thirty per cent myelocytes. Five months later he showed 6,900,000 red blood cells, 9,800 leukocytes with only eight per cent myelocytes. Two years later the patient showed 8,292,000 red blood cells, 23,200 leukocytes with no myelocytes. It should be noted that in this case Winter believed the patient showed polycythemia at the time he was first diagnosed leukemia.

* From the Department of Internal Medicine, University of Kansas School of Medicine, Kansas City, Kansas.

Ghiron in 1922, described a patient with the typical picture of myeloid leukemia, who in the course of eight months developed polycythemia. The first blood count showed R.B.C. 2,100,000; W.B.C. 320,000 with six per cent myeloblasts and forty-five per cent myelocytes. Eight months later the red blood cells had increased to 7,200,000. Naegeli in 1931, described a similar case.

During the past two years we have seen three patients with myeloid leukemia who also showed the typical blood picture of polycythemia vera. They are reported here as another contribution to this interesting subject:

CASE REPORTS

Case I—C. S., female, age 31.—This patient, a young white woman, was first seen on April 18, 1941, complaining of enlargement of the spleen. Physical examination showed a large spleen extending to the right past the midline and downwards to the level of the iliac crest. The blood count at this time showed R.B.C. 4,300,000, W.B.C. 100,000, Hb. sixty-eight per cent (10.5 gm.). The differential count showed lymphocytes three per cent, neutrophiles sixty-eight per cent, eosinophiles three per cent, metamyelocytes eight per cent, myelocytes fifteen per cent, myeloblasts two per cent. The patient received four x-ray treatments, two of 140 roentgens each to the anterior surface of the spleen and two of 140 roentgens each to the lateral surface of the spleen.

At the time of her dismissal from the hospital on May 9, 1941, the patient's spleen was approximately one-third of its original size. Her white blood count had fallen from 100,000 to 7,400, the hemoglobin remained unchanged at sixty-eight per cent. The patient's general health apparently improved rapidly. On May 21, 1941, her blood examination showed R.B.C. 5,040,000, W.B.C. 7,850, Hb. eighty-one per cent (12.5 gm.); on June 14, 1941, R.B.C. 4,660,000, W.B.C. 19,000, Hb. ninety per cent (fourteen gm.); on July 12, 1941, R.B.C. 6,130,000, W.B.C. 17,200, Hb. 106 per cent (16.5 gm.). Coincident with this increase in the number of the red blood cells, the myelocytes which totalled seventeen per cent on April 18 fell to two per cent on July 12, 1943. This patient moved to California where Dr. Marcus A. Krupp at the Stanford University Hospital on September 23, 1941, found that the patient's red blood count had increased to 8,150,000, leukocytes 22,000, hemoglobin 135 per cent.

Case II—S. J., female, age 49.—This patient was first seen on August 9, 1942, complaining of pain in her left leg. Physical examination showed a large spleen extending four cm. below the costal margin.

The cervical and axillary lymph glands were enlarged. The blood examination at this time showed R.B.C. 3,380,000, Hb. seventy-one per cent (eleven gm.), W.B.C. 272,000 with ten per cent metamyelocytes and fourteen per cent myelocytes.

The patient was dismissed from the hospital on August 29, 1942. She had received two x-ray treatments, a total of 314 roentgens, her spleen was much reduced in size, the white blood count was 14,550.

The patient returned for observation on April 30, 1943. The blood examination at this time showed R.B.C. 6,320,000, Hb. 106 per cent (16.5 gm.), W.B.C. 16,450 with a normal differential count except for eleven per cent basophiles, three per cent metamyelocytes and two per cent myelocytes. The total blood volume (Congo Red method) was eighty cc. per kilo (normal sixty-six cc.), total plasma volume thirty-five cc. per kilo (normal forty cc.), total red cell mass forty-five cc. per kilo (normal twenty-six cc.). The patient's spleen was approximately the same size as on her first admission. She was dismissed May 3, 1943.

She returned June 18, 1943, her blood examination at this time showing R.B.C. 4,360,000, Hb. eighty-seven per cent (13.5 gm.), W.B.C. 271,000 with thirty-two per cent metamyelocytes and ten per cent myelocytes. The total blood volume at this time was seventy-seven cc. per kilo (normal sixty-six cc.), total plasma volume forty-five cc. per kilo (normal forty cc.), total red cell mass thirty-two cc. per kilo (normal twenty-six cc.). The patient received four x-ray treatments to the spleen, a total of 584 roentgens. She was dismissed from the hospital on June 22, 1943, the white blood count having fallen to 73,000.

Case III—D. R., male, age 65.— This patient was first seen on October 5, 1941, when his chief complaint was excessive bleeding from minor injuries. Physical examination showed a large spleen extending ten cm. below the costal margin. The liver was also enlarged. The blood count at this time showed R.B.C. 5,230,000, Hb. eighty-three per cent (12.8 gm), W.B.C. 26,400 with two per cent matamyelocytes. Later reports showed one per cent myelocytes.

The patient has been under observation nearly two years. During this period the highest red count observed was 6,160,000, the highest leukocyte count 49,150, the highest recorded myelocyte count one per cent. The blood on June 11, 1943, showed R.B.C. 5,485,000, W.B.C. 25,400, Hb. eighty-four per cent (thirteen gm.). No abnormal cells were seen in the blood smear. The total blood volume per kilo was 117 cc. as compared with the average normal of sixty-five cc., the plasma volume sixty-one cc. per kilo (normal thirty-five cc.) and the total red cell mass was fifty-six cc. per kilo (normal thirty cc.).

SUMMARY

In the three patients reported the blood pictures of myeloid leukemia and polycythemia (erythremia) were present at the same time. Case I, when first seen, had the typical picture of myeloid leukemia with 100,000 white cells and fifteen per cent myelocytes with a normal red count but showing a definite reduction in hemoglobin. Two months later she showed R.B.C. 6,130,000 with 106 per cent hemoglobin (16.5 gm.), the characteristic findings of polycythemia vera. In this instance it seems apparent that the patient first developed myeloid leukemia and polycythemia followed later.

The same conclusion seems justified in Case II. This patient when first seen showed the typical picture of myeloid leukemia with 272,000 white cells and fourteen per cent myelocytes, and a secondary anemia. Three months later her red blood count had increased from 3,380,000 to 6,320,000 the hemoglobin from seventy-one per cent to 106 per cent. The blood volume studies showed the typical fiindings of polycythemia vera.

The third patient when first seen showed the picture of polycythemia vera with a marked leukocytosis. Myelocytes and metamyelocytes were scarce but present from time to time. Here the process is reversed in comparison with Cases I and II or else the patient first developed myeloid leukemia but was not studied until the later polycythemia appeared. If Case II had been seen first on April 30, 1943, instead of August 9, 1942, we should have concluded falsely that polycythemia developed first and was followed by leukemia.

Some observers have advanced the theory that in this condition where the blood picture is that of both leukemia and polycythemia, the same stimulus acting on the bone marrow causes an increased production of both erythrocytes and leukocytes, the latter often showing abnormal forms. An alternate conception is that the polycythemia is a protective action of the bone marrow against the rapidly developing anemia of myeloid leukemia.

The possibility that roentgen therapy may have caused the appearance of polycythemia after improvement of the leukemia should be considered. In Case I and Case II polycythemia appeared after roentgen treatment for leukemia; Case III received no roentgen treatments at any time.

The most commonly employed terms for this condition are "myelogenous polycythemia" (Blumenthal), "erythroleukemia" (di Guglielmo), "subleukemic erythremia" (Aubertin), and "hyperplastic

panmyelopathy" (Askanazy). We have employed the term erythroleukemia because of its simplicity, without necessarily accepting the view of di Guglielmo that there "is a reversion on the part of the clasmatocytoid hemohistioblast to its embryonic activity so that it produces erythrocytes as well as leukocytes."

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TUBERCULOSIS CONTROL

COLLEGE CAMPUSES IN THE FIGHT AGAINST TUBERCULOSIS*

The Twelfth Annual Report of the Tuberculosis Committee of the American Student Health Association gives striking proof of the value of a tuberculosis control program as a regular part of student health service. In the 311 progressive colleges and universities (total student enrollment, 558,075) reporting such programs, 744 new cases of tuberculosis were discovered, a rate of 133.5 new cases per 100,000 students. At 177 colleges (total student enrollment, 146,000) which provided no such programs, eleven new cases came to light, a rate of 7.5 per 100,000 students. Twenty-two food handlers were found to have pulmonary tuberculosis, and among faculty and other administrative officers, forty new cases were discovered, thus bringing the total of new cases found in colleges during the school year 1941-1942 to 817.

Few diseases impose such costly and far-reaching penalties for public or personal failure to provide early diagnosis as does tuberculosis; yet the majority of institutions of higher education in this country still fail to employ modern tuberculosis case-finding methods, which are simple and not expensive. The years of disability and suffering and the financial costs involved will reach staggering propertions, and there will be numerous deaths whenever we neglect early diagnosis of tuberculosis.

It is estimated that the complete cost of finding an undiscovered case of tuberculosis among college students on now unprotected campuses might run as high as $166. This may seem expensive to some, who do not take into account the social and economic values involved in the early diagnosis of the disease. Failure to provide modern case-finding programs, however, will invariably prove far more costly to unfortunate individuals, families and communities, and can never rebound to the credit of a negligent institution.

The tuberculin test provides the most sensitive and reliable index of the prevalence of tuberculous infection. In the young adult group, for the country as a whole, 21.8 per cent of students react to tuberculin, the east and west coast sections having a higher infection rate than other sections of the country.

Many of the older, largely exploded, ideas relating to tuberculosis seem still to be firmly lodged in the minds of many people. The belief is all too prevalent that early tuberculosis gives rise to early symptoms. Certain institutions report various procedures for the follow-up of "suspects." "Weighing at frequent intervals," "frequent temperature readings," are among the more common of these. The "suspects" are usually those students who are markedly underweight. The Committee therefore feels justified in emphasizing again the fact that the tuberculin test and the chest x-ray provide the only adequate means for the early detection of presymptomatic tuberculosis in the vast majority of cases.

Although it is not possible to speak in exact terms of the incidence of tuberculosis as applying to the country's student population, reports available to the Committee seem to indicate a decline of approximately thirty per cent in its prevalence among college students during the past six years. This may be on the conservative side, for during this period re-

* Tuberculosis Among College Students, H. D. Lees, M.D., The Journal-Lancet, April, 1943.

ports from many of the larger institutions conducting excellent case-finding programs indicate an extension of these procedures to include a higher percentage of their students. It is evident that more students are being examined each year and the technics employed have improved and become more effective.

That there are various technics used in tuberculin testing is shown in Table 1. The Mantoux intradermal method continues to lead all others while P.P.D. and O.T. are fairly even choices in testing materials. A comparatively large number of colleges use the two-dose technic.

TABLE 1

Testing Technics in 254 Colleges Reporting Tuberculin Testing Programs, 1941-42

Testing Method:	
Mantoux intradermal	182
Vollmer patch test	54
Pirquet	4
Combined Mantoux and patch test	3
Unspecified	11
Testing Material:	
Purified protein derivative	93
Old tuberculin	89
Combination of the two	1
Testing Dosage:	
Two-dose technic	63
Single large dose	35
Single intermediate dose	37
Single small dose	37
Combination of dosages	2
Testing Routine:	
New students and all negative reactors annually	63
New students only (no retesting)	49
New students and all seniors	29
Test optional (available to all annually)	47
Other testing routines	46

Sixty-six colleges report the ideal annual x-ray of positive reactors. The various x-ray procedures reported are indicated in Table 2.

TABLE 2

X-Ray Procedures Reported by Various Institutions, 1941-42

254 Colleges Reporting Tuberculin Testing Program:	
Positive reactors x-rayed once	74
Positive reactors x-rayed annually	66
X-ray optional (acceptance general)	60
X-ray optional (acceptance not satisfactory)	10
Other x-ray routines	19
Fluoroscope used routinely to supplement x-ray	38
Fluoroscope used exclusively (chest x-ray when indicated)	12
57 Colleges Reporting No Tuberculin Testing Program:	
Chest x-ray for all new students	22
Chest x-ray for all students annually	9
Other routine x-ray programs	26

During the school year 1942-1943 the Committee enlisted the cooperation of a group of eastern colleges in a study of entering students approximating 10,000 in number. Information concerning each student includes age, home address, name and location of secondary school attended and whether a private, public, or parochial school; tuberculin test technic and results; and x-ray findings. It is hoped that this survey may continue without interruption for a period of ten years or longer, thus providing data indicating differences in the prevalence of tuberculous infection among students from various states and various home communities, accurate yearly comparisons, as well as supplying an index of any changes in the prevalence of tuberculous infection among students in this area.

MEN IN SERVICE

In this issue we are instituting a new column "Men in Service," which we hope will be of interest to our members at home and those in service.

Some of the news that reaches our desk cannot of course be published, either in full or in part, due to rigid censorship regulations. Names of ships, locations of divisions and units and various other things are taboo, however, it is possible to use some re-printed matter and news releases at times.

We will greatly appreciate first-hand news of our members in service. Please send this direct to the Journal office.

W. M. MILLS, M.D., Editor.

Kansas newspapers recently carried the news that Capt. William E. Wilson, formerly of Greensburg, previously reported as missing in action since the fall of Corregidor more than a year ago, is now a prisoner of war of the Japanese in the Philippine Islands.

Capt. H. Penfield Jones of Lawrence, now in Africa, has been promoted to the rank of major as of May 16.

Dr. Harold Warnock, formerly with Dr. Earl Brown in New York (Kansas members will remember Dr. Brown who was with the Kansas State Board of Health) writes from ———— that with Capt. Leslie Saylor of Topeka, he had just returned from a short furlough by foot and by jeep. Captain Saylor, he says, is recuperating from an attack of dengue fever.

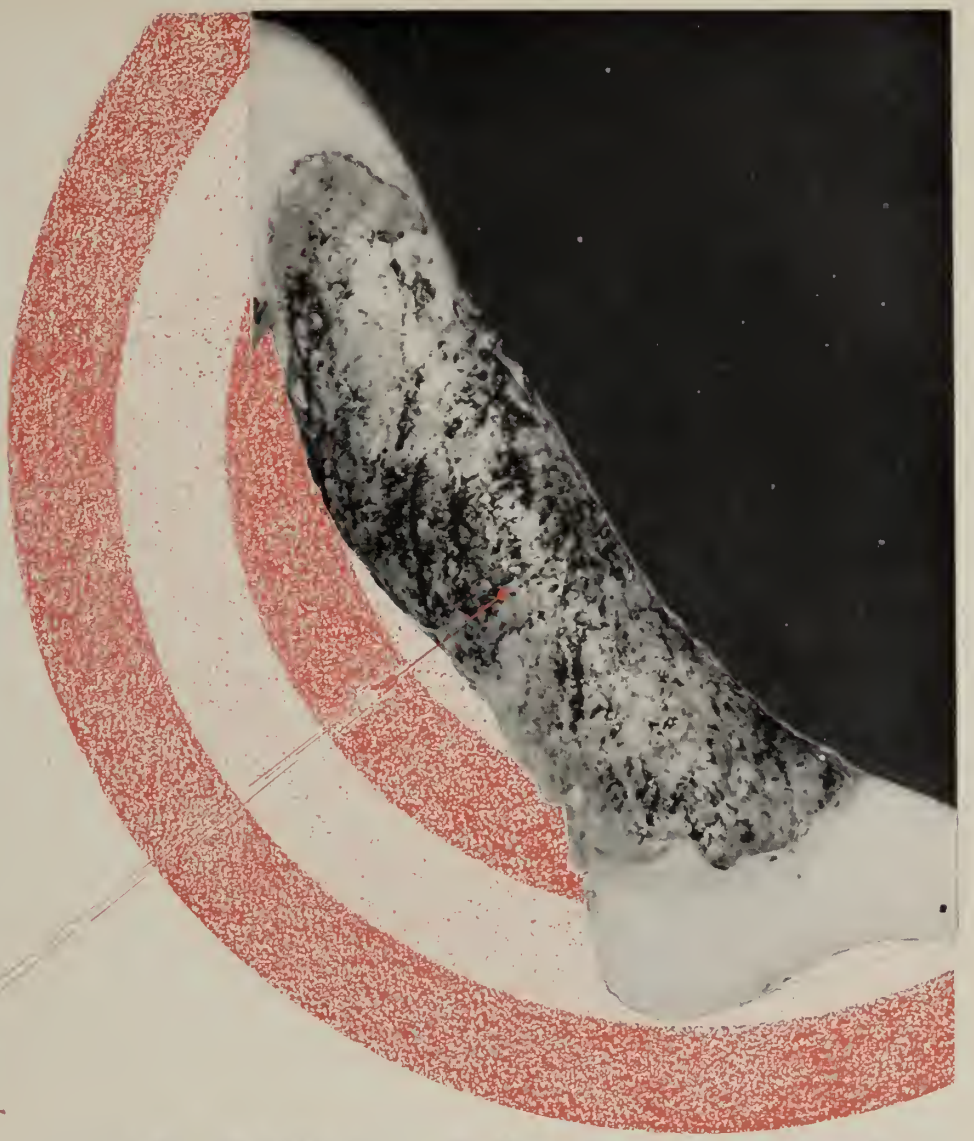
An associated press dispatch recently announced that Col. Edgar E. Hume, formerly commanding officer of Winter General Hospital in Topeka, has been appointed as chief American health officer of occupied Sicily.

Major Mahlon Delp of Kansas City, has been promoted to lieutenant colonel in the Army. Lt. Col. Delp has served in England and in North Africa and has recently returned to the United States.

Lt. D. R. Davis, M.C., formerly of Dodge City, has been commissioned as a captain and is now located at Fort Bliss, Texas.

Capt. Warwick Thomas Brown of the Medical Corps of the United States Navy, was a visitor in Topeka. He has recently returned from duty in Guadacanal.

A letter from Lt. Ernest C. Moser of Holton, published in the Sabetha Herald has the following to say: "Our unit consists of thirty doctors and other administrative officers—all of the states being represented. Our work is very interesting at times and at other times dull. During a battle the hospital is about like a large general hospital on Saturday night and during a lull it resembles a quiet average





HITTING THE TARGET

For second-degree burns, physicians are finding that Ointment Morco with Sulfathiazole is scoring highly with their patients. Results of its application show it stimulates ephithilization and granulation, thereby resulting in rapid healing with a minimum of scarring.

This product, developed by the Archer-Taylor Laboratories, combines cod liver oil (vitamins A and D) with sulfathiazole 5 per cent, wool fat, benzocaine, phenol, boric acid and zinc oxide. Each gram of ointment contains at least 390 U.S.P. units of vitamin A and 55 units of vitamin D.

Your prescription druggist has Ointment Morco with Sulfathiazole, or can obtain it through his regular source of supply. If you haven't used it yet, write and we'll gladly send you a generous trial supply.

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hospital. The sulfa drugs and plasma have certainly saved many lives and have improved the treatment over that of World War I. Africa is much different than most of us thought."

Capt. Clyde B. Trees of Topeka, is now stationed in Ashville, North Carolina. Dr. Trees writes that he is planning to take the American Board of Surgery examination in New Orleans in the near future.

The June issue of War Doctors carried a short article about Dr. Lyle S. Powell, now Colonel Powell, who is stationed at Camp Robinson, Arkansas.

Major Emmerich Schulte, formerly of Kansas City, and stationed at O'Reilly General Hospital from where he was sent to Chicago for post graduate work, has recently been transferred to Camp Edwards, Massachusetts.

Capt. M. Donald McFarland of Kansas City, has been transferred to Modesto, California.

Lt. H. H. Crank of Topeka, has been transferred from pre-flight school in Iowa City to Farrgut, Idaho.

Capt. Frederick W. Hall of Winfield, has been transferred from induction center at Fort Des Moines to Station Hospital at Camp Hale, Colorado.

Major Orville R. Clarke of Topeka, stationed for a time at Lawson General Hospital in Atlanta, Georgia, has been transferred to North Africa.

Lt. Francis A. Thorpe of Pratt, has been transferred from Santa Ana, California, to Hamilton Field, California.

Lt. Charles Pokorny of Attica, has been transferred from Mather Field, California, to Santa Ana, California.

Capt. A. C. Baird of Parsons, has been transferred from Indianapolis to Beaver Dam, New York.

Lt. Joe G. Reed of Larned, has been transferred from Carlisle, Pennsylvania, to Fort George Wright, Washington.

Major William M. Brewer of Hays, has been transferred to Camp Gruber, Oklahoma, and writes to the Journal as follows: "Will you please change the mailing address of the Journal. I wish to assure you of my appreciation in continuing my name on your mailing list and my interest in the activities of the Kansas Medical Society."

Capt. A. A. Sprong, formerly of Sterling, and a flight surgeon in the Air Corps, has recently been promoted to the rank of major. Major Sprong received an award for meritorious achievement in the Solomon Islands. He has served in Hawaii, Midway, the Solomon Islands, New Zealand, New Caledonia, New Hebrides and Guadalcanal. At the present time Major Sprong is stationed at Strothers Army Air Field in Winfield.

Lt. L. G. Graves of St. John, stationed for some time at Kelly Field, Texas, now has an APO number out of San Francisco.

Lt. R. M. Wyatt of Hiawatha, who was formerly stationed at Perrin Field, Texas, is now in Enid, Oklahoma.

Capt. Fred H. Haigler of Cherokee, is now stationed at North Platt, Nebraska.

Clippings received from many Kansas newspapers have announced that the following doctors are now stationed in North Africa: Lt. J. G. Gaum, formerly of Ellinwood; Capt. William Weston, formerly of Arkansas City; Capt. Marlin W. Carlson, formerly of Ellinwood, and Dr. Ray Leiker, formerly of Great Bend.

Dr. Raymond C. Clapp of Wichita, formerly a lieutenant has been commissioned as a captain in the Army. Capt. Clapp is stationed at Carlisle, Pennsylvania.

Lt. Arthur Gulick, son of Dr. A. C. Gulick of Goodland, has recently been promoted to the rank of lieutenant commander in the Navy. Lt. Comdr. Gulick is stationed at Dutch Harbor, Alaska.

Lt. Frank K. Bosse of Atchison, has been promoted to the rank of captain and is now stationed at March Field, Riverside, California.

Lt. Comdr. B. I. Krehbiel of Topeka, writes that his new address is in care of a fleet post office of San Francisco.

Lt. William Spencer Fast of Atchison, has been transferred from Lawson General Hospital at Atlanta, Georgia, to Fort Riley.

Recent Kansans' graduating from the school of aviation medicine at Randolph Field, Texas, are: Lt. Ernest A. Cerv of Wichita, Lt. Fowler B. Poling of Halstead, Lt. Lyle B. Putnam of Wichita and Lt. Lee Emerson Rook of Wichita, who graduated on April 22. The June 3 class list included: Major Morris R. Blacker of Wichita, Lt. George R. Maser of Mission and Lt. Leland P. Randles of Fort Scott. The July 10 list included Lt. Harold L. Graber of Topeka, as a graduate of the school of aviation psychologists.

The July 15 class that graduated from the School of Aviation Medicine had six Kansas members: Lt. Clovis W. Bowen of Valley Falls, Lt. Donald E. Bux of Manhattan, Capt. Arnold F. Nothnagel of Kansas City, Lt. Edward H. Stratemeier of Wichita, Lt. Ronald C. Vetter of Lawrence and Lt. Paul B. Young of Wichita.

Lt. Harold F. Spencer of Garnett has recently been transferred to Philadelphia, Pennsylvania, where he will be enrolled in a post graduate course in anesthesia. Lt. Spencer was originally stationed in Minneapolis, Minnesota, and later in the United States Naval Hospital at Great Lakes, Illinois, before being sent to Philadelphia.

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NEWS NOTES

PROCUREMENT QUOTA

Plans for meeting the 1943 Kansas quota of physicians for the armed forces were completed at a meeting of the Medical Procurement and Assignment Committee held in Topeka, Sunday, September 12th. Dr. Forrest L. Loveland, Chairman, of Topeka, and the entire committee composed of: Dr. W. M. Mills of Topeka, Dr. C. C. Nesselrode of Kansas City, Dr. Marion Trueheart of Sterling, Dr. Henry N. Tihen of Wichita, Dr. Alfred O'Donnell of Ellsworth, Dr. Clyde D. Blake of Hays, Dr. N. E. Melencamp of Dodge City, and Dr. C. S. Huffman of Columbus, were present.

Due to the fact that the Kansas medical profession had done such an excellent job of meeting its 1942 quota, no quota was set for Kansas by the national office until a short time ago. In order to meet the demands of the armed forces, more physicians will be called from Kansas. The meeting, which lasted all day, was occupied with careful considerations of the civilian needs of each county in Kansas.

Assisting in these deliberations were: Dr. J. L. Lattimore, President of the Kansas Medical Society; Dr. H. R. Wahl, Dean of the Kansas University School of Medicine; Dr. Charles R. Rombold, Chairman of the Kansas Medical Society Industrial Hygiene Committee; Dr. F. C. Beelman, Secretary of the Kansas State Board of Health; Lt. Col. Seth A. Hammel, State Selective Service Medical Officer; Robert A. Brooks, Secretary of the Kansas Medical Society, and Mrs. Sula S. Goodman, Secretary for the Procurement and Assignment Committee.

CLINICAL SOCIETY MEETINGS

Announcement has been received that three adjoining state clinical societies have scheduled their conferences for the month of October. It is hoped that many of our membership can attend one or more of these meetings which, according to the scheduled program, will be of interest to all physicians. With the curtailment of the scientific sessions of state meetings, the district or clinical society programs have the added advantage of easy access to a well rounded scientific meeting of general interest.

The Kansas City Southwest Clinical Society will hold its twenty-first annual fall clinical conference in the Municipal Auditorium in Kansas City, Missouri, on October 4-6, 1943.

Emphasis has been placed on the subjects of interest to men doing general work both in the planning of the assemblies and the refresher courses. Ten refresher courses, covering practical phases of medicine, surgery and the specialties, will be presented on Tuesday and Wednesday mornings of the conference. New and interesting scientific and technical exhibits will be shown.

The guest speakers are as follows: Dr. Harrison F. Flippin of Philadelphia, associate in medicine of the University of Pennsylvania; Dr. Charles Gordon Heyd of New York City, clinical professor of surgery of New York Postgraduate Medical School; Dr. Frank H. Lahey of Boston, director of the Lahey Clinic; Dr. William F. Megert of

KANSAS CITY SOUTHWEST CLINICAL SOCIETY

Twenty-First Annual Fall Clinical Conference

Kansas City, Missouri, October 4, 5, 6, 1943

HARRISON F. FLIPPIN, M.D., F.A.C.P., Philadelphia, Pa.
CHARLES GORDON HEYD, M.D., F.A.C.S., New York City.
FRANK H. LAHEY, M.D., F.A.C.S., Boston, Mass
WILLIAM F. MENGERT, M.D., Iowa City, Iowa.
EDWARD H. RYNEARSON, M.D., F.A.C.P., Rochester, Minn.
TOM D. SPIES, M.D., F.A.C.P., Birmingham, Ala.
CYRUS C. STURGIS, M.D., F.A.C.P., Ann Arbor, Mich.
PAUL DUDLEY WHITE, M.D., F.A.C.P., Boston, Mass.
GEN. PAUL HAWLEY, M.C., U.S.A. Chief Surgeon, European Theater Operations
COL. REX L. DIVELEY, M.C., U.S.A. Orthopaedic Consultant, European Theater Opr.

Round Table Discussion, October 4th. Military Program (Evening) October 4th.
Information Please Program (Evening) October 5th.
Refresher Courses, October 5th and 6th. Alumni Dinners, October 6th.

Scientific and Technical Exhibits and Luncheons, Daily

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Iowa City, associate professor of obstetrics and gynecology of the State University of Iowa; Dr. Edward H. Rynearson of Rochester, Minnesota, assistant professor of medicine of the University of Minnesota Graduate School; Dr. Tom D. Spies of Birmingham, Alabama, associate professor of medicine and director of nutritional research of the University of Cincinnati; Dr. Cyrus C. Sturgis of Ann Arbor, Michigan, professor of internal medicine of the University of Michigan; General Paul Hawley, chief surgeon of the European Theater of Operation, will discuss the medical service in the European Theater; Col. Rex Dively, orthopaedic consultant will present movies in relation to the war, and Dr. Paul Dudley White of Boston, lecturer in medicine of Harvard Medical School.

The Monday evening program for the Kansas City Southwest Clinical Society meeting will be entirely military.

The eleventh annual assembly of the Omaha Mid-West Clinical Society is scheduled to be held at the Hotel Paxton in Omaha, Nebraska, on October 25-29, 1943. There will be a symposium on pneumonia, shock and peripheral vascular diseases, and one on war medicine and surgery.

The Oklahoma City Clinical Society thirteenth annual confrence will be held in Oklahoma City at the Biltmore Hotel on October 18-21, 1943. Additional information on the program is given on Page 308 of this issue of the Journal.

The following speakers will appear on the program: Dr. A. H. Aaron, professor of clinical medicine of the University of Buffalo; Dr. Vilray Papin Blair, professor emeritus of clinical surgery and professor emeritus of oral surgery of the Washington University of Medicine; Dr. Louis A. Buie, professor of surgery of the University of Minnesota, Mayo Foundation; Dr. Leroy A. Calkins, professor of obstetrics and gynecology of the University of Kansas School of Medicine; Dr. Theodore J. Dimitry, director of the department of ophthalmology and professor of ophthalmology of the Louisiana State University and professor of special anatomy of Loyola University; Col. Franklin G. Ebaugh of the Medical Corps, A. U. S. of the headquarters of the Eighth Service Command of Dallas, Texas, now on leave for military service from the University of Colorado Medical School where he was professor of psychiatry and director of the Colorado Psychopathic Hospital; Dr. George B. Eusterman, professor of medicine of the University of Minnesota, Mayo Foundation; Dr. Charles Brénton Huggins, professor of surgery of the University of Chicago; Dr. Clinton W. Lane, instructor of dermatology of Washington University School of Medicine; Dr. Harry E. Mock, associate professor of surgery of Northwestern University School of Medicine; Dr. Thomas G. Orr, professor of surgery and head of the department, University of Kansas School of Medicine; Dr. Louis E. Phaneuf, professor of gynecology of Tufts College Medical School; Dr. Robert D. Schrock, professor of orthopedic surgery of the University of Nebraska School of Medicine; Dr. John A. Toomey, professor of clinical pediatries and contagious diseases of Western Reserve University School of Medicine; Dr. W. Likely Simpson, professor of otolaryngology and head of the department, University of Tennessee; Dr. Charles T. Way, assistant clinical professor of medicine of Western Reserve University School of Medicine, and Dr. J. W. Amesse of Denver, Colorado, the Vice-President of the American Medical Association.

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ANNOUNCING THE THIRTEENTH ANNUAL CONVENTION OF THE OKLAHOMA CITY CLINICAL SOCIETY

October 18, 19, 20, 21, 1943

DISTINGUISHED GUEST SPEAKERS

DR. A. H. AARON, Medicine, University of Buffalo.

DR. VILRAY PAPIN BLAIR, Plastic Surgery, Washington University School of Medicine.

DR. LOUIS A. BUIE, Proctology, Mayo Foundation, University of Minnesota School of Medicine.

DR. LEROY A. CALKINS, Obstetrics, University of Kansas School of Medicine.

DR. THEODORE J. DIMITRY, Ophthalmology, Louisiana State University

FRANKLIN G. EBAUGH, Colonel, M. C., Neuropsychiatry, Headquarters, Eighth Service Command, Dallas, Texas.

DR. GEORGE B. EUSTERMAN, Medicine, Mayo Foundation, University of Minnesota School of Medicine.

DR. CHARLES BRENTON HUGGINS, Urology, University of Chicago School of Medicine.

DR. CLINTON W. LANE, Dermatology, Washington University School of Medicine.

DR. HARRY E. MOCK, Surgery, Northwestern University School of Medicine

DR. THOMAS G. ORR, Surgery University of Kansas School of Medicine.

DR. LOUIS E. PHANEUF, Gynecology, Tufts College Medical School.

DR. ROBERT D. SCHROCK, Orthopedic Surgery, University of Nebraska School of Medicine.

DR. JOHN A. TOOMEY, Pediatrics, Western Reserve University School of Medicine.

DR. W. LIKELY SIMPSON, Otoloryngology, University of Tennessee School of Medicine.

DR. CHARLES T. WAY, Medicine, Western Reserve University School of Medicine

DR. J. W. AMESSE, Vice-President, American Medical Association, Denver, Colorado.

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FRACTURES & TRAUMATIC SURGERY—Two Weeks Intensive Course starting October 18.
GYNECOLOGY—One Week Personal Course in Vaginal Approach to Pelvic Surgery starting November 1. Clinical and Diagnostic Courses.
OBSTETRICS—Two Weeks Intensive Course starting October 4.
ANESTHESIA—One Week Course in Continuous Caudal Anesthesia for Obstetrics.
OPHTHALMOLOGY—Two Weeks Intensive Course starting September 27. Course in Refraction Methods October 11.
OTOLARYNGOLOGY—Two Weeks Intensive Course starting September 13.
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In that especially critical anemia case—as in all the others—you need a product of the caliber of

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CHANGES IN MILITARY HONOR ROLL

Since the publication of the Kansas Military Honor Roll in the July, 1943, issue of the Journal we find that a few names were omitted, some given to us in error and some few have served for a few months or years and then been returned to the home front.

Dr. Harold O. Closson of Ashland, from Clark County, is now in the Navy. Reno County can list Dr. W. E. Wendel of Buhler, and Saline County can add the name of Captain Mark Dodge of Salina, as in the service. Lt. Com. A. J. Rettenmaier of Kansas City, is stationed at McIntire Dispensary at Great Lakes and can be added to the list from Wyandotte County. Barton County can add Dr. Kenneth R. Grigsby; Brown County, Lt. Edgar Paul Sereres of Horton; Harvey County, Captain R. T. Unruh of Halstead; Ellis County has Dr. Alza McDermott in the Navy; Leavenworth County now has Lt. Peter Schott Combs, and Stevens County has recently sent Capt. Wm. R. Kenoyer of Hugoton. Some few of these men have gone into service since the list was completed but others names were omitted. We would appreciate being advised of any other names which might have been omitted in the July list.

Dr. F. L. Loveland is in receipt of a letter from Mrs. C. E. Keeton of Paola, which gives us information on Dr. Elvin E. Keeton, who had previously been reported to us as killed in action. The letter reads: "We were so glad it was all a mistake and will be very much pleased to have it known by all the membership that our son Dr. Elvin E. Keeton is very much alive and working busily in Clinton, Oklahoma. Although he was on the ill-fated Lexington when she sunk, he had a big swim and came out without a scratch and has since been in a naval air station in the United States." Dr. Keeton is now a lieutenant commander.

We have been informed that we were in error in listing Dr. John G. Swails of Doniphan County as in the service.

Dr. Walton Woods of Riley County, Manhattan, has informed us he is not in service and therefore his name should not have appeared in the list.

We would like, at this time, to add the names of some of our members who have served in the United States from a few months to a year or more and who have for various reasons been relieved from duty to come home and again take up their practice on the home front:

Lt. Col. L. B. Gloyne, Kansas City	Army
Capt. Durell K. Knight, Kansas City	Army
Capt. John H. Luke, Kansas City	Army
Lt. Charles M. Starr (Larned) now Halstead	Army
Capt. George A. Chickering, Hutchinson	Army
Capt. Thomas E. Johnson, Topeka	Army
Lt. Arthur C. Antony, Clyde	Army
Lt. Thorton Lewis Wayland, Nashville	Army
Capt. Anthony Rossitto, Wichita	Army
Lt. Guy E. Finkle, McPherson	Army
Frank Foncannon, Emporia	Army
Capt. Orville C. McCandless, Marion	Army

KANSAS PRE-NATAL LAW

On July 1, 1943, the new Kansas pre-natal examination law went into effect. The law was passed by the 1943 legislature and requires physicians in the state attending expectant mothers to take or cause to be taken, within fourteen days after diagnosis is made, a sample of blood which is then submitted to either a private laboratory or

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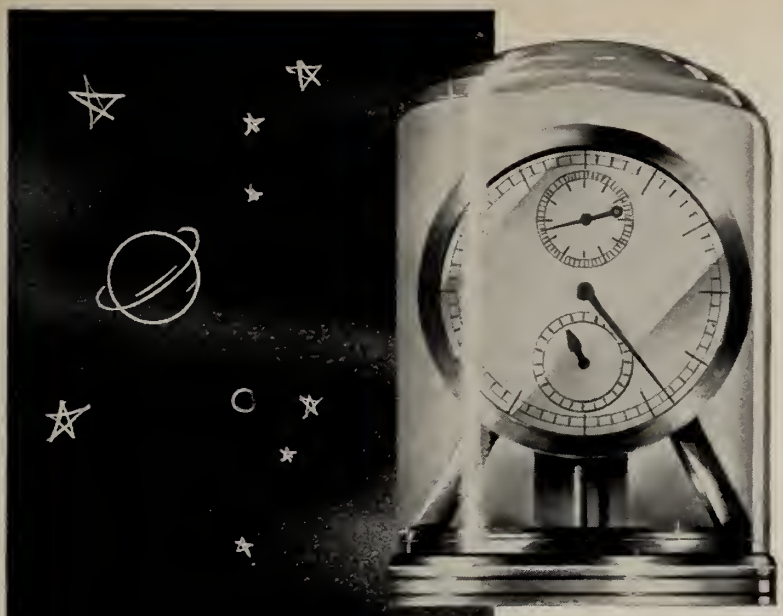
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the laboratory of the Kansas State Board of Health.

The law as enacted reads as follows:

"An Act relating to public health, providing pre-natal serological tests for syphilis, and prescribing certain powers and duties and providing penalties for the violation thereof.

"Be it enacted by the legislature of the state of Kansas:

"Section 1. Each physician or other person attending a pregnant woman in this state during gestation, shall, with the consent of the patient in the case of each woman so attended, take or cause to be taken a sample of blood of such woman within fourteen days after diagnosis of same is made, and submit such sample for standard seriological test for syphilis to either a private laboratory or to the public health laboratory of the state board of health at Topeka or to laboratories cooperating with the state board of health. The result of all laboratory tests shall be kept confidential and shall be reported on standard forms prescribed and furnished by the state board of health.

"Section 2. In reporting every birth and stillbirth, physicians and others permitted to attend pregnancy cases are required to report births and stillbirths shall state on a separate sheet accompanying the birth certificate or stillbirth certificate, as the case may be, whether a blood test for syphilis has been made during such pregnancy upon a specimen of blood taken from the woman who bore the child for which a birth or stillbirth certificate is filed, and if made the date when such test was made, and if not made, the reason why such test was not made. Neither the fact that such a test was or was not made or was or was not required by law nor the result of any such test shall appear upon the birth certificate or be certified to any person for any purpose.

"Section 3. Any person willfully violating any of the provisions of this act shall be deemed guilty of misdemeanor, and upon conviction shall be fined a sum not less than ten dollars nor more than one hundred dollars.

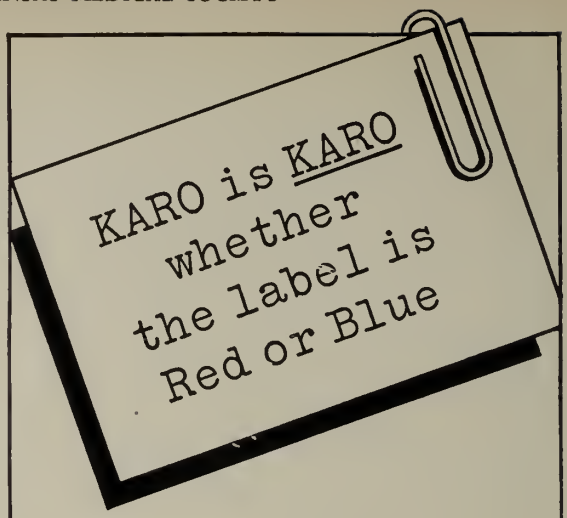
"Section 4. This act shall take effect and be in force from and after its publication in the statute book."

The forms for recording tests may be secured from your local registrar or from the Kansas State Board of Health. However, in no event is the birth certificate itself to contain information as to the results of the tests.

PLASTICS IN ADVERTISING

One advertisement page in the August issue of the Journal created a great deal of stir in the printing office. For years the men in the printing shop and the pressmen have prepared metal ad cuts for publication of the Journal using the same old methods, but in August they were faced with an entirely situation. When the Philip Morris advertising plate arrived in the office, the Journal force and the printing plant could not believe that a cut had come in such a light weight package. On being opened, it was found to be plastic, the first advertising plastic cut that had come to the printing company's attention. The Kansas Industrial Development Commission were advised and all watched the printing of that issue with many misgivings.

Our printers were asked for a written report on the outcome and their letter follows: "We are inclosing the last impression from the plastic plate furnished by your advertiser for the current issue of your Kansas Medical Journal. I think you will be as pleased as we are with the results. Our pressman tells us that this plate, apparently, requires a little more make-ready than copper faced electrotypes, but with the metal shortage perhaps this is the answer to the problem.



Your patients may have a preference for either Red Label *or* Blue Label KARO. If their grocers are temporarily out of their favorite flavor, you may assure them that *flavor* is the only difference between these two types of KARO for infant feeding.

Each contains practically the same amount of dextrins, maltose and dextrose so effective for milk modification.



How much KARO for Infant Formulas?

The amount of KARO prescribed is 6 to 8% of the total quantity of milk used in the formula—one ounce of KARO in the newborn's formula is gradually increased to two ounces at six months.

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No food (except breast milk) is more highly regarded than Similac for feeding the very young, small twins, prematures, or infants who have suffered a digestive upset. Similac is satisfactory in these special cases simply because it *resembles breast milk so closely,* and normal babies thrive on it for the same reason. This similarity to breast milk is definitely desirable — *from birth until weaning.*

A powdered modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butterfat is removed and to which has been added lactose, olive oil, coconut oil, corn oil, and cod liver oil concentrate.

ARMY NAVY
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One level tablespoon of Similac powder added to *two* ounces of water makes *two* fluid ounces of Similac. This is the normal mixture and the caloric value is approximately 20 calories per fluid ounce.

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"As you know this plate just ran a couple of thousand impressions but it looks like it is good for many more."

Plastics, which are made from soy beans, natural gas, water, air and coal are transformed into gun blocks, transparent noses for Liberator planes, safety-eye-protectors for our war workers, kitchen and laboratory equipment (ware) and many other items. This new innovation in the field of printing should result in a great saving of metal and lessen the already over-loaded shipping problem. The office of the Industrial Development Commission has written for permission to use the cut as publicity in the plastic display at the State Fair and elsewhere.

CARRYING THE TORCH FOR SERVICE MEN

Whenever a doctor enters the military service he leaves behind him a hard won medical clientele, a following of many years, a long list of faithful patients and a factor of good will which will take him many years to re-build into the kind of practice he left behind. A doctor's patients are a matter of personal confidence and trust and when service to them is broken by the doctors absence it is often not renewed.

Physicians in the state of Ohio have instituted a new plan for those of their members who have entered the military service. They are in the slang of our times "carrying the torch for their members in the profession now in service." The Ohio State Medical Society has published the following card or placard which has been placed in the offices of many Ohio physicians:

OUR OBLIGATION

"Perhaps the physician who has been providing you with medical service is one of the many Ohio physicians now on duty with the Army and Navy. While he is making this sacrifice for you and me, you can count on those of us who remain on the home front to do our utmost to meet your medical needs.

"However, it is my sincere hope that when your doctor returns, you will again resume your former relationship with him.

....., M.D."

MILITARY SURGEONS MEETING

The Association of Military Surgeons of the United States will hold its 51st meeting in Philadelphia on October 21-23, 1943. The symposium on war medicine will be of general interest. It is expected that some 2,000 doctors, many who have been in active combat, in every camp and base throughout the country and on our fighting fronts will attend. Announcement of the plans for the convention

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were released through Rear Admiral William L. Mann, of Seattle, Washington, the president of the association. Besides the general session, the program lists forum lectures, teaching panels and films on various subjects. Offices of the Association are in room 603, 1520 Locust Street, Philadelphia, Pa.

POST-GRADUTE COURSES IN DISEASE OF THE CHEST

Postgraduate courses in disease of the chest were sponsored, by the University of Kansas School of Medicine, the Kansas State Board of Health, the Kansas Tuberculosis and Health Association and the Kansas Medical Society, in several cities in the state during the week of August 28 to September 5.

Speakers for the course were as follows: Dr. Carl C. Birkelo, assistant in radiology of Wayne University College of Medicine and Dr. Henry C. Sweany of the University of Chicago School of Medicine.

The courses were held in the following cities: In Kansas City on August 28 and 29; in Parsons on August 30 and 31; in Wichita on September 1 and 2; in Salina on September 2 and 3; and in Emporia on September 4 and 5. Although it was necessary to limit the number of enrollments all of the classes were well attended.

COMMENTING ON THE WAGNER BILL

The Wagner bill is getting a great deal of comment in the newspapers of the country. The following are bits from news articles or editorials recently published:

"It is not at all evident that this is a purpose for which the majority will impose taxes. Observers in Washington do not expect the Wagner bill to pass in this Congress. Many Americans instinctively reject a kind of paternalism—however well-intentioned — which not only considers the individual so childish that he must be forced to save, but forced to save for some purpose the state regards as most beneficial to him. Some may think he should be made to save for a better house or extra food or a vacation in the country rather than more medical treatment. Others believe the individual should be left to join a voluntary group for insuring medical care if that's what he wants.

"But the compulsory health insurance section is only one of several questionable features in a vast project which should be most thoroughly questioned even by those who believe security can be insured by law."—Christian Science Monitor.

"POLITICAL OPIATE—A bill has been introduced in Congress which proposes to have the Government extend medical and hospital benefits to approximately 110,000,000 persons in the United States. If made a law, it would cost the people, roughly, $3,000,000,000 annually in taxes to support what the advocates of the bill like to call 'free' medical care. This is nearly as much as the total cost of maintaining the Federal Government each year on the average from 1924-33. In addition, the entire fund would be at the disposal of one man, the Surgeon General of Public Health Service who by law would become a medical director. We are indeed a sick nation if we are willing to swallow such a pill. After swallowing it we would find that instead of taking a progressive stimulant we had taken a political opiate intended to dull our senses to an uncompromising truth soundly expressed by the Lake County,



"don't smoke"...

is advice hard for patients to swallow. May we suggest, instead, *SMOKE "PHILIP MORRIS"?* Tests showed 3 out of every 4 cases of smokers' cough cleared on changing to PHILIP MORRIS. Why not observe the results for yourself?

Indiana, Medical News: 'It is only in an atmosphere of freedom that the lamp of science and learning can be kept alight. In all the history of the race progress has never flowered in a subject people. It is only free men who dare think and it is only through free thought that the soul of a people can be kept alive.'—Lyon News, Lyon, Kansas.

"LOOK UNDER THE SHELL—When a federal agency tempts you with the promise of something juicy for your money, look under the shell before you hand out any cash because you may find something different there from what you had been led to expect by the smooth-tongued come-on artists. . . .

"Now take a look at the joker in the bill. If made into law, this 'free' medical care provision, its speciousness sugared under the guise of humanitarianism, would amount to more than you think if adopted in the form it was presented in a bill introduced into the senate by Senators Robert F. Wagner of New York and James Murray of Montana.

"The plan would cost the people annually in Social Security taxes more than three billions of dollars to provide this 'free medical care.'

"Besides that, the entire fund would be at the disposal of the Surgeon General of the Public Health Service, who would become medical dictator and would control not only doctors, but hospitals, medical schools, dentists, nurses and students.

"State medicine—political control of medical service—always has meant and always will mean for the mass of people medical care through and by physicians who are politically amendable rather than by those with superior skills and abilities.

"For the doctor, state medicine means the necessity of catering to the politician rather than first and foremost to the needs of the human beings who are his patients.

"If the medical profession can be seized lock, stock, and barrel by government, what about the industries that clothe, house, feed and transport us? All of them are vital to our well-being. Why not write a law, seize the whole works and call it by its right name—communism?

"Better leave that pill under the shell and tell those economic atheists whose crackpot theories have reduced the domestic front in Washington to a state of bedlam and who are promoting this medical shell game to try and find their suckers elsewhere." — Independence Daily Reporter, Independence, Kansas.

"POLITICAL MEDICINE — The bill is a vicious one when its full significance is understood. . . . Under the Wagner bill, the Surgeon General would have the power to transfer physicians from one part of the country to another, as he sees fit; to dictate to them what services they individually may render; how many patients they may serve; and what charges they may make. . . .

"People become deeply attached to their family physician. They trust him and think he can cure them if a cure is possible. Confidence in him inspires them to hope even in hopeless situations. When you or your loved ones are ill, you want your own family physician. . . .

"But should the Wagner bill become the law, it will just be lucky for you if your favorite doctor is able to answer your call. He already may have the patients the Surgeon General has allotted him and the illness you wish treated might happen to be one the Washington dictator declares out of his sphere. In which case you would have to consult a different physician than the man of your choice, and even might be forced to employ as your physician, to get anybody, the man you often declared you 'wouldn't let doctor a sick cat.'

"The regimentation of medicine would put a damper on original research and experimentation. Had we had po-



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litical medicine we most probably would not have had the sulpha drugs, the serums and the many other new remedies to cure human ills and prolong man's life expectancy. There would be no incentive for research. And according to the provisions of the law, all medical schools would be subsidized by the government and would be under the direction of the Surgeon General.

"For the best good of our people, American physicians must be free to work along original and individualistic lines. And Americans must be free to consult the physician of their choice. Such arbitrary control of medical practice as is contemplated in the Wagner bill, is utterly foreign to American concepts and to the American way of life."

MEMBERS

In the recent issue of the Bulletin of the American College of Radiology, Dr. Lewis G. Allen of Kansas City, was listed as a member of the Board of Chancellors and a member of the Commission on Public Relations and Dr. Arthur K. Owen of Topeka, as a state councilor. Other Kansas men listed as fellows were: Dr. O. R. Brittain of Salina, Dr. Guy A. Finney of Topeka, Dr. Galen M. Tice of Kansas City and Dr. Opie Swope of Wichita. Kansas members were: Dr. John T. Swanson of Independence, Dr. P. E. Hiebert of Kansas City, Dr. Marion Trueheart of Sterling, Dr. H. H. Woods of Topeka, Dr. Earl J. Frost of Wichita, Dr. Newman C. Nash of Wichita and Dr. Anthony F. Rositto of Wichita.

Dr. Henry Asher, formerly county health officer of Sedgwick County and more recently director of local health service of the Kansas State Board of Health, recently resigned that position to become health officer of Algen and Schoolcraft counties in Michigan. Dr. Asher will have offices in Manistique, Michigan.

Dr. E. J. Beckner of Pratt, has recently been appointed as health officer of Butler County with offices in El Dorado.

Dr. John A. Billingsley of Kansas City, was elected as Vice-President of the Kansas City Eye, Ear, Nose and Throat Society at its annual meeting held in Kansas City on May 20.

Dr. Otto J. Hartig, formerly of Downs, has been made medical director of Hill Crest Memorial Hospital in Tulsa, Oklahoma.

Dr. Arthur E. Hertzler of Halstead, is the author of an article entitled, "Value of Basal Rate in Goiter," which was published in the May, 1943, issue of the Journal of Southern Medicine and Surgery. Dr. Hertzler presented the paper at the recent Tri-State Medical Association Meeting.

Dr. J. H. Humphrey of Wichita, has moved to Moreland, Oklahoma.

Dr. John W. Neptune of Salina, was announced as an associate fellow of the American Medical Association. Dr. Neptune's fellowship was approved at the session of the council which was held in Chicago during the annual meeting.

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DEATH NOTICES

Dr. Charles Edmund Caswell, 73 years of age, died on June 12, of cerebral thrombosis and arterial sclerosis, at his home in Wichita. He was born in Macon, Missouri, and was graduated from the Kansas Medical College of Topeka in 1902. He was an honorary member of the Sedgwick County Medical Society.

Dr. Albert Henry Marshall, 67 years of age, died on June 7, of coronary thrombosis at his home in Topeka. He was born in Topeka, February 25, 1876, and was graduated from the University of Oklahoma School of Medicine in 1914. He was a member of the Shawnee County Medical Society and the Association of Railway Surgeons.

Dr. William Frederick Nienstedt, 69 years of age, died on July 6, of coronary thrombosis and sclerosis, at his home in Hartford. He was born in St. Louis, Missouri, on November 6, 1874, and was graduated from the Kansas City Medical College in 1898. Dr. Nienstedt was an active member of the Lyon County Medical Society.

Dr. Brette Redpath Riley, 72 years of age, died at his home in Benedict on July 16, of coronary embolism. He was born in Miami County, near Paola, on January 28, 1871, and was graduated in 1896 from the Central Medical College of St. Joseph, Missouri. He was a member of the Wilson County Medical Society.

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CLASSIFIED ADVERTISEMENTS

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Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

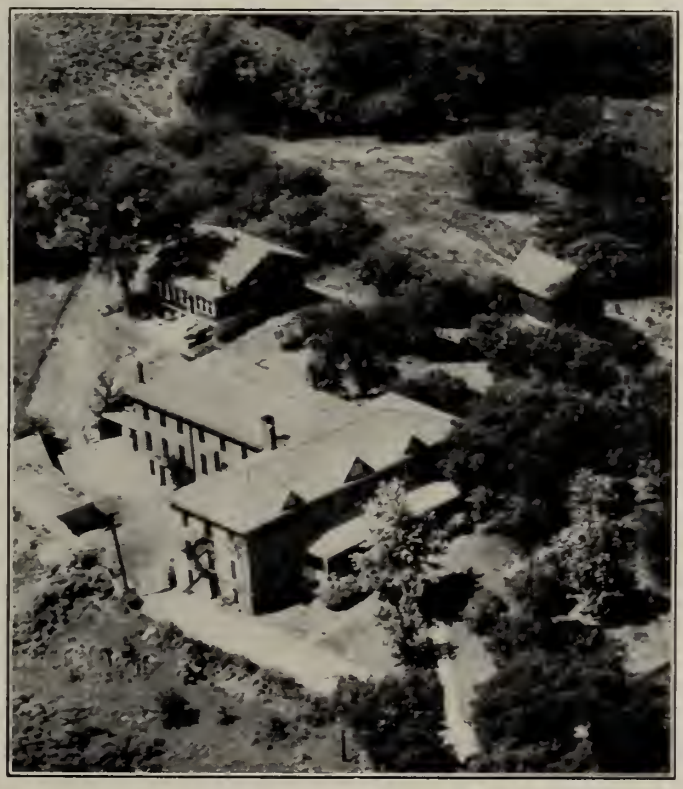
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PRESIDENT'S MESSAGE

The program outlined by the National Auxiliary this year is very comprehensive and practical, too. Each Auxiliary that carefully studies this outline and uses all that it can, will have a much better informed membership. We are not just another club, but have very definite objectives to promote. Make your program the most vital part of your Auxiliary.

There are many ways in which the Woman's Auxiliary to the American Medical Association can assist our country in winning the war. The national chairman of the War Service Program, a newly created committee, suggests we give active support to those agencies that are responsible for the maintenance of an adequate Army and Navy after the war; cooperation with the industrial health program of the A.M.A. so that the health of the workers is maintained. Constant education in nutrition is of value to the civilian population. She urges less civilian travel so that we have efficient transportation of our armed forces and to help in the selling of war bonds and stamps. One of the greatest fields of active work of the Auxiliary is to help procure sixty-five thousand high school graduates to enlist for nurse's training. Auxiliaries near army camps are asked to inquire if they can be of assistance to medical officers and their families. Maybe recreational rooms should be provided. Have a central location where all communications may be received and continue educational programs so that the public will realize the necessity of maintaining our present standards.

Your President will be glad to be of any assistance to you.

Sincerely, Mrs. E. E. Tippin.

AUXILIARY NEWS

The Women's Auxiliary to the Shawnee County Medical Society entertained with a desert luncheon at the home of Mrs. H. T. Morris in Topeka on September 13. Mrs. C. E. Joss and Mrs. H. B. Hogeboom were the assisting hostesses. Dr. J. L. Lattimore, President of the Kansas Medical Society brought greetings to the Auxiliary and Major Mathew Peelen of the staff of Winter General Hospital spoke to the group on "Winter Hospital."

OTHER STATE AUXILIARIES

"The Woman's Auxiliary to the Iowa State Medical Society was organized May 9, 1929. When we terminate our state convention today, we shall have concluded fourteen years.

"We have a membership of 336 with 41 members-at-large and fifteen organized counties. No new counties have been organized this year, but we have 31 new members-at-large and one county contemplating organization."—Iowa State Medical Journal.



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FUNDAMENTALS OF PSYCHIATRY XI

MENTAL DYNAMISMS

William C. Menninger, M.D.

Topeka, Kansas

That portion of the personality which we call the Ego must maintain itself against the powerful drives from the unconscious Id, the criticism of the tyrannical Super-ego and the demands of external reality. We can recognize certain methods which the Ego uses to maintain this equilibrium, methods which are necessary for psychic efficiency and economy.

These methods might be compared to various plays which a football team uses to advance the ball. The team carrying the ball represents the Id; the opposing team which never knows exactly what is going to happen corresponds with the Ego; the crowd functions as does the Super-ego, an onlooker and critic. In one play the team may use a forward pass, in another, an end run, in another, a line buck. In every case these plays represent a device which is expressed as a dynamic move, with the chief aim of finding an opening or a hole through which a wish (the football) can reach the outside world (the goal post).

These various plays of the mind which are known as "dynamisms" and "mechanisms" are always unconscious. The Ego is never aware of the particular style of play that is being used against it. The conscious part of the individual does not know when he uses a particular mechanism. If for some reason the particular method does become conscious it is no longer to be regarded as a dynamism. These dynamic devices are used in all mental processes, in health as well as in disease. They are reflected in our thinking, our dreaming, our phantasy life, in all our relationships with other people, and in our behavior.

The dynamisms serve three purposes: first, they give expression to the Id demands and thus eliminate or relieve tension. Secondly, they serve to protect the Ego against two major dangers in external reality. The Ego is always afraid of losing its sources of love; all of us fear loss of approval from a critical world, and to protect ourselves from this, we utilize certain of these unconscious dynamic devices. A second reality danger is the fear of injury to the self, or even threat of injury, which has been described at some length in a previous installment of this series as the fear of castration. In addition, these devices have the third purpose of protecting the Ego against the internal danger of the loss of approval of the Super-ego, the conscience.

DEFINITIONS AND EXAMPLES OF THE DYNAMISMS

A classification of the various dynamisms is extremely difficult and unsatisfactory since each of these is used in varying degrees in both adjustment and maladjustment. The first eight listed are more frequently utilized as aids to maintaining good adjustment, but as is indicated under each one, they are used frequently and extensively in maladjustments.

1. COMPENSATION: A device which the individual uses to neutralize a feeling of insecurity by making prolonged and excessive strivings in the direction in which the insecurity is felt. The extensiveness of this effort depends upon the intensity of the threatened insecurity.

Examples in health: One can find many examples of genius exhibited in men who overcame infirmities and succeeded spectacularly in spite of their infirmities. Thus, Milton although he was blind, let his pen follow along a steel wire to write "Paradise Lost." Beethoven, though deaf, composed most of his symphonies after his deafness was far advanced. There are many evidences in every day life of compensation for physical handicaps. Some people of small stature compensate for their unconscious feeling of inferiority by making themselves conspicuous, or by creating an impression of being very important or very intelligent or very ponderous. The persons with bad teeth or a disfigured face or deformed limbs all develop methods of compensating for these which are entirely unrecognized by themselves. Still other compensations are found in the people who are "too honest," or "too diligent," or "too liberal," who even make their friends wonder why they must go to such extremes.

Examples in maladjustment: Some of the over-compensations seen in sickness are identical with the dynamism referred to below as the "Reaction Formation." In a severe depression we find an individual who because he masturbated in adolescence now feels that he is "eternally damned" and unfit to associate with others, and to compensate for this he must punish himself eternally. His punishment represents the compensation to appease his sense of guilt. In some schizophrenic individuals we see an entire reversal of the personality; an individual who in health may be conspicuous because of his attention to cleanliness or politeness, may go to the extreme of untidiness and rudeness in a psychotic state.

2. SUBLIMATION: A method by which the primitive sexual impulses demanding gratification obtain an outlet in modified forms through the conversion of this energy into socially approved activities.

Example in health: Sublimations in the healthy individual correspond to symptoms in the sick individual. Thus, all sublimations are essentially healthy in nature. The capacity for sublimation varies widely in different individuals. It is expressed in minor ways in hobbies: thus, collecting is very definitely related to the anal phase of psychosexual development when the individual over-evaluated his excretory products, and because of this over-evaluation wanted to keep them, or collect them. Sublimation is exemplified in major ways in the choice of a vocation. Thus, the nurse or the kindergarten teacher may resign her desire or hopes for children and find satisfaction in the care of many children or patients; her pupils or her patients become her children. The primitive desire and gratification obtained in infancy through the infliction of pain or cruelty is sublimated in the butcher, and perhaps in a more refined way in the surgeon. The infantile gratification of power, dominance, independence, and collecting in the anal stage, all find outlets in an approved fashion in the banker.

Examples in maladjustment: The capacity for sublimation is reduced in maladjustments, and the more intense the maladjustment, the less is this capacity. Consequently, in the severe illnesses there are essentially no sublimations.

3. RATIONALIZATION: This is the device for explaining plausibly (and thus accounting for or justifying) certain feelings, ideas, or behavior, the explanation appearing to be the result of logical thinking. It is the Ego's way of defending the irrational demands of the Id.

Examples in health: In all sincerity all of us at times blame our mistakes or blunders on the decree of fate. We explain our feelings on the basis of the weather. When we do not want to do anything we can usually find a justifiable reason for not doing it, or when we want to do something badly enough we can find a reason for doing it. Rationalization does not refer to consciously concocted explanations, but rather to those sincere and apparently logical explanations of our attitudes and behavior. One does not often force himself to give explanations for most of his ideas or behavior; yet, if one is confronted with the question of why he likes carrots, why he fell in love with his wife, why he prefers blue, why he chooses brunettes, he may himself suspect the inadequacy of his answers.

Examples in maladjustment: Every patient attempts to justify his delusions, and he does so with a sincerity that makes his mistaken idea a conviction and not a misunderstanding. Invariably, the individual addicted to the use of drugs is convinced of the logic of his explanation as to why he started it. An individual addicted to alcohol is sincere in his belief that he began drinking to escape his troubles or his sorrow.

4. SYMBOLIZATION: This dynamism is an unconscious process built up on associations of similarity, whereby one object comes to represent or stand for (symbolize) another object through some part or quality or aspect which the two have in common. We must differentiate unconscious symbolization from conscious symbolization which is equally widespread, as for instance, the fraternity pin, the diamond ring, the cross, and even language.

Examples in health: The most fertile fields for examples of symbolization are found in dreams, in literature, in mythology and fairy tales, and in art. There are perhaps not more than a hundred objects which are commonly symbolized but there are thousands of different symbols used for this group of objects. Thus, the father is represented very frequently by the king, God, the director, the executive. The body is frequently represented as a house or as a building. The phallus is represented by any pointed object, a spire, dagger, sword, gun. Many of our common symbols in everyday life have lost their original significance: thus, the Maypole came originally from a ceremony of phallic worship; the foot is used to symbolize speed, foundation, power, fecundity.

Examples in maladjustment: The dreams of the maladjusted individual show the same symbolization. Certain compulsions like hand-washing symbolize the individual's desire to rid himself of something, usually guilt.

5. INTROJECTION: The unconscious incorporation by an individual of the emotional attitude,

the wishes, the prohibitions, or the ideals of another person or persons, insofar as they serve as sources of pleasure. By this dynamism the individual gains possession of the desired object.

Examples in health: The Super-ego is formed through the incorporation of the parental attitudes of right and wrong, of good and bad. One goes to a party and if he has a good time even without any effort on his part he has succeeded in incorporating "the spirit of the party." When in love an individual often wants to incorporate the object of his love, giving rise to such familiar sayings as "I love you so much I could eat you."

Examples in maladjustment: In explaining the dynamic factors in depression, it has been shown conclusively that the individual with a depression first loses some love object. In his depression he incorporates this love object into himself. He appears to punish himself, but unconsciously he is punishing this incorporated love object because of its desertion. In many cases this may even lead to suicide, in which the individual kills this introjected former love object, now regarded as his enemy. In schizophrenia we occasionally see individuals who hear voices emanating from various parts of their body, which in each case represent an introjected object split off from the conscious life.

6. IDENTIFICATION: By this dynamism the individual unconsciously acquires the attributes of another person or object, which represents an ideal or model for him. Identification can be thought of as an unconscious imitation.

Examples in health: One finds many instances of identification in childhood, in which the child characteristically picks out his hero, wants to be like him, to imitate him. Even in adulthood an individual may adopt the dress, or the posture, or manner, or speech, of someone of whom he is very fond. It is often noticeable that two people who live together over a period of years frequently assume similar mannerisms or even appearances which are noticeable to their friends. One can observe the identification by many individuals with the heroine in the picture show who cry where she cries, and laugh when she laughs. Most of us identify ourselves with the football team on the two-yard line, and are likely to push against the person next to us in an effort to get the ball across the line. When those of us who are used to driving cars become merely passengers we usually "put on the brakes" around each fast turn.

Examples in maladjustment: An unconscious identification often occurs in minor states of mental ill health. It is often said, and certainly is a fact, that some husbands suffer much more than their wives do when the latter are in labor. Often the conversion symptoms of hysteria like blindness or paresthesias, represent an unconscious identification with one of the parents. In psychotic individuals one frequently finds the delusion that the individual thinks he is Napoleon, Jesus, or the Virgin Mary. We recently had a lawyer in the hospital who unconsciously identified himself with his guilty client and upon winning an acquittal for his client he himself developed delusions of guilt and a severe depression.

7. CONDENSATION: By this dynamism several ideas are telescoped into a single word, phrase, or symbol, for the sake of psychic economy, and to obscure the underlying meaning of the ideas. One idea then may appropriate the total emotional value of several ideas.

Examples in health: The best examples of condensation are seen in dreams, in which one person or object represents the fusion of several persons or objects by the combination of traits of each. Thus, one may dream of a man with long hair, the condensation of both mother and father. Slips of the tongue often represent condensation in which the individual starts to say one word, changes his mind faster than his tongue can work, and ends in coining a new word, expressing both his ideas. Examples of this latter are frequently used as a form of wit, such as "extemperoneously," referring to after dinner speeches; "anecdotage," referring to that stage of life when one is in his dotage and anecdotes are a daily menu; "alcoholiday," referring to the two ideas of imbibing alcohol and taking a holiday.

Examples in maladjustment: Many of the slips of speech indicate a conflict in the desire between the conscious and the unconscious. Thus, one wants to be very polite because the situation demands it, though he feels very unkindly. In his effort to be very polite he makes a slip of speech and indicates in a condensed form his whole feeling of animosity. In schizophrenia we occasionally find individuals whose speech is so jumbled that it is described as "word-salad," and one must presume that these always represent condensations. The conversion of an unconscious idea or wish into a physical symptom as seen in hysteria can be understood only in the light of condensation; the physical symptom represents a long train of associations, finally crystallized in one form.

8. IDEALIZATION: One may say that most individuals fail to see their own faults, and it is through this dynamism that we lack this critical ability about ourselves. Likewise, when one is in love he assumes that his girl is perfect; she is the most beautiful girl, the sweetest girl, "the only girl."

Examples in maladjustment: One must assume that those individuals who are entirely blind to every fault in their behavior and relationships to people, are maladjusted. Technically, they are regarded as being extremely narcissistic; in the layman's term they are conceited. Sometimes the overevaluation of the person is the way in which the individual can disguise even from himself his great animosity or hostility for that person. The prototype of this reaction is illustrated in the famous Dickens' character of Uriah Heep in "David Copperfield," in which for many years the "meekness" of Uriah permitted even himself to believe that he was devoted and faithful to his master only to turn out to be the opposite when the opportunity arose.

The following dynamisms are also present in both health and illness. They are utilized perhaps a little more frequently, however, in maladjustment or threatened maladjustment, and many of them are referred to by some psychoanalysts as "defense" dynamisms.

9. REPRESSION: By this mechanism painful and unpleasant ideas are excluded from consciousness, and thus from motor expression, which prevents conscious conflict. Infantile desires and impulses and ideas which are incompatible with or painful to the individual's conscious life are excluded from the field of awareness by this process, repression.

Examples in health: Everyone utilizes the mechanism of repression, the extent of repression is roughly proportionate to one's idealism, i. e., the more idealistic one is in his concept of life and his pattern of behavior, the more he has to repress; the more primitive he is in his ideation and behavior, the less he has to repress. Everyone must repress and does so with varying degrees of success. Thus in the well adjusted individual most of the infantile desires are successfully held in check, including such material as the Oedipus situation, the castration fears, and the primitive modes of gaining sexual satisfaction.

Examples in maladjustment: When repression fails the Ego is weak, since repression is one of its functions. The infantile Id demands gain gratification either in a disguised form, as in the neuroses, or by direct expression, as in the psychoses. One can experimentally release repressions to some degree by the use of alcohol. In acute alcoholic intoxication the individual expresses his more primitive desires and ideas, and indulges in behavior which he will not permit himself when sober.

10. ISOLATION: This is a mechanism by which the emotional feeling associated with the memory of a painful impression or experience is lost, and thus the memory appears to be colorless, of no importance, and not connected with any emotion.

Examples in health: By isolation a person may recall a very unhappy childhood experience without any of the emotional distress which originally accompanied the experience.

Examples in maladjustment: Very often the precipitating factor, if it is one particular incident, in either a neurosis or psychosis may represent this dynamism. For instance, a patient observes another person spit up some blood and then subsequently develops a tuberculosis phobia. There is no apparent recognition on the part of the patient of why this particular thing should start the phobia. The causes of the original fear are lost and the emotional response becomes attached to this particular incident. In the type of illness known as an obsessional neurosis, the patient goes through many ceremonials, for instance, as in opening or closing a door. These ceremonials are substitutive actions to prevent the return of certain old associations. By isolation the emotion of these old associations is lost and the particular act appears to be colorless and of no importance.

11. UNDOING: In this dynamism there is an unconscious attempt through a symbolic act to undo or abolish a past experience or impression which has been painful to the Ego.

Examples in health: This mechanism represents an irrational form of negative magic, seen in certain superstitions. Thus, if a black cat crosses one's path the person can "undo" the harm by turning around three times. This same dynamism underlies many folk customs and religious ceremonials. It is usually the basis for sacrificial offerings, on the assumption that by sufficient sacrifice the past experience is undone.

Examples in maladjustment: Again in the illness of obsessional neuroses the ceremonials like handwashing represent an attempt to "undo" past experience. In the depressions the individual frequently tries to punish himself, thus atoning for his guilt.

12. REACTION FORMATION: (Reversal) This dynamism refers to the development in the conscious life (the Ego) of attitudes and interests which are the exact opposite of unconscious attitudes or interests. Thus, a person says or does the opposite of the real unconscious wish. It necessitates a shift of the emotional trends from a set of ideas objectionable to the conscious to an opposite set of ideas which is not objectionable.

Examples in health: Many of the worth while character traits of the adult have been seen to originate during the anal phase of the psychosexual de-

velopment. Any of these traits, however, can become exaggerated; thus, extreme orderliness, excessive cleanliness, over-emphasis on punctuality, and many other conscious socialized attitudes may represent the opposite of the unconscious wish. In other words, the unconscious demands may be for disorderliness, dirtiness, and to protect the personality and hold these in check the Ego must over-react. In popular language it "leans over backwards," to deny more strongly the unconscious desires. Thus, the expressions of the Ego represent a reaction to the unconsciously desired action.

Examples in maladjustment: In many psychotics one may see behavior which is strikingly opposite from that displayed in their normal life. Thus, the individual who may be very polite (painfully so) in normal life, becomes exceedingly discourteous and irascible in a psychotic state. In many of the severe phobias the particular fear usually disguises a source of pleasure. Often the patient himself is impressed with how frequently he sees some reference to his particular fear, as if he were actually hunting actively for the object of the fear rather than trying to escape it. One can often recognize that the excessive solicitude on the part of relatives may be a disguise for hate. Recently we saw a nurse who had nearly wrecked her own physical health by attempting to meet the demands of an exceedingly neurotic sister. The sister had refused to eat and actually lost so much weight that her life was in danger. The nurse was strongly urged to leave the patient under the physician's care and to stay away, with the frank admission that the future was in doubt but that it would certainly be more hopeful than if the nurse insisted on taking care of her. Even though the nurse was told that the sister would probably die if she continued to care for her, she insisted on so doing under the guise of great devotion to and affection for the patient, though it actually cloaked a great hostility.

13. FIXATION: This process is not always classified as a dynamism because it is not always a device used in the release of tension from the Id. It is the arrest of some part of the libido at one or another pleasure-finding stage of development, i. e., an excessive amount of libido is arrested at the oral phase or at the anal phase.

Examples in health: Fixation occurs normally in some degree at all stages of development, so that everyone develops to some degree indirect outlets for this gratification like smoking, or sublimated gratifications like singing.

Examples in maladjustment: The fixation of a large part of the libido at any of the developmental stages produces outstanding character trends which are described as "oral" and "anal" characters.

14. REGRESSION: This process also is not a dynamism because it is not merely a device to relieve tension. It refers to the retreat by the libido from any particular psychosexual level to a lower level of development.

Examples in health: Regression does not occur in health unless one includes temporary situations like physical illness, or being under the influence of alcohol. In the case of physical illness one loses interest in the outside world, depending on the severity of the disease, and his libido instead of being invested in many objects or persons entirely retreats to an investment in himself, a narcissistic investment. Likewise, under the influence of sufficient alcohol an individual retreats from his normal psychological level to a simpler level. Regression takes place to some degree as old age approaches, and the layman is familiar with the implications in the phrase "the second childhood."

Examples in maladjustment: Regression takes place in any situation in which the individual's efforts to invest his libido are frustrated, thus, by the lack of love or by unsuccessful competition. When this investment is slight so that it gives only a small amount of gratification, or for various reasons may be insecure, the individual may back up in his development to an earlier level, where his previous methods of gratification have been proven. Regression occurs in varying degrees in all types of mental illness, but is more marked in the deteriorating types like schizophrenia, organic disease reactions, and senility.

15. DISPLACEMENT: This is a dynamism by which the emotional value attached to one idea or person is transferred to another idea or person. The individual expresses an emotional attitude toward an object which is either out of proportion to it, or unrelated to it. When this displacement of emotional attitude takes place in the psychotherapeutic situation it is referred to as transference; it may be positive (a feeling of love) or negative (a feeling of hate.)

Examples in health: Whenever we misplace the blame or credit for a feeling which we have we use the mechanism of displacement. Thus, the upbraiding of the roommate at the end of a hard day's work at the store is a displacement of the feeling which is really directed toward the disagreeable customer. The lavishing of affection on a dog by a society matron is a displacement from a desire to lavish affection on a child. When one exhibits an excess of anger or other emotion over any trivial incident he must recognize that the emotion is in actuality dis-

placed from some other situation to which it relates. The immediate liking or disliking of a person on first meeting is the result of displacement, in which also the mechansm of identification plays a role.

Examples in maladjustment: Chronically ill people are prone to displace their feelings to any part of the environment and thus develop the reputation of being "cranky" or irritable. When the parents fail to manage their child often they take out this failure on the child in scoldings or whippings. In mental illness the ceremonial procedures of the obsessional neurotic represent a displacement of feeling.

16. UNCONSCIOUS PHANTASY: This dynamism refers to the phantasy life of the unconscious which, since it is phantasy, is free from the restraint of reality.

Examples in health: The desires of the unconscious even in the well-adjusted, are always of major importance in determining the behavior and mode of life of the individual. Normal childhood unconscious phantasies include the Oedipus and castration situations, birth theories and ideas of procreation. In psychoanalysis we have learned of many ways in which the individual lives out in real life many of his unconscious desires, never having recognized the motives for his behavior.

Examples in maladjustment: The unconscious phantasy life accounts for the formation of symptoms and symptoms themselves are an expression of the unconscious phantasies. They result because of conflicting desires of which the patient is unaware; for instance, the patient may have a great unconscious hostility towards the father which he may displace to anyone in the environment who in any way represents the father. Dreams may always be said to represent unconscious phantasies, and their unintelligible character is in part due to our failure to recognize the desires and wishes of the unconscious.

17. AMBIVALENCE: This is a dynamism by which the Ego expresses simultaneously a love for and hostility toward an object, one of which is consciously denied. This process is usually not classified as a dynamism, but is a concept to describe the bipolar nature of a conscious attitude.

Examples in health: One may say that all love is tempered with an equal quantity of potential hostility. This is shown when the loved one is deceptive and the deception provokes a much greater hostility than would the same deception in an unloved person. Before the deception the hostility is denied; after the deception the love is usually denied.

Examples in maladjustment: This simultaneous feeling of love and hate is often cloaked by a compensatory or reaction formation, again illustrated by the over-solicitousness of relatives. Psychiatrists have come to recognize that over-evaluation of any person may be a protective device to cloak an equal amount of unconscious hostility. For instance, the patient may often regard his father as the "most wonderful person in the world," and make no criticism of him, when on deeper analysis one finds that the patient's attitude is actually a reaction formation to cloak hostility for the father.

The following dynamisms are most often evidenced in those who are the poorly adjusted, but minor examples can be cited in many apparently normal individuals.

18. CONVERSION: This dynamism refers to symbolic expressions of repressed wishes through physical symptoms, either motor and sensory. In addition to representing the repressed desires the symptom also represents a defense on the part of the Ego against the direct expression of the repressed wishes.

Examples in health: Conversion symptoms do not appear in health, though minor conversions occur frequently in many individuals who are not sufficiently neurotic to justify any particular diagnosis. Thus, one may develop a headache which excuses him from attending a funeral. He may develop a stiff neck which prevents him from playing a tennis match. In both instances he has the conscious intention and desire to go to the funeral or play the match.

Examples in maladjustment: Conversion symptoms are best illustrated in the illness known as conversion hysteria in which many types of physical symptoms may be manifested, like blindness, loss of voice, paralysis, anesthesia, contractures. In all instances these can be shown to be functional by many criteria, most spectacularly by hypnosis.

19. PROJECTION: A dynamism in which the individual to protect himself from his sense of insecurity transfers to another person or object his own wishes or his own inadequacies.

Examples in health: This mechanism does not occur in good health although many people who are fairly well adjusted often resort to it in minor ways. Thus, they blame their partners for all the mistakes in the card game. They excuse their own failures on the basis of someone else's errors. All those individuals given to being somewhat suspicious resort frequently to this dynamism. Thus, they believe that they don't get the "breaks" because the world or their employer or wife or associates or someone is against them.

Examples in maladjustment: The ideas of reference to other people result when a feeling of in-

security makes a person uncertain of the attitude of others. In its extreme form projection is the basis of paranoid delusions in which the individual projects his own unrecognized desires or motives to other people. Projection of the perceptive ability results in hallucinations.

20. DISSOCIATION: A dynamism by which ideas or associated groups of ideas known as complexes may become split off from the main personality and continue a separate existence. This process is not always classified as a dynamism, but merely as a descriptive process in the division of the stream of consciousness.

Examples in health: There is the normal dissociation of physiological functions from the stream of consciousness. Thus one is not aware ordinarily of his heart beating or of his stomach digesting, even though they are parts of him. There are many incongruities that occur in normal life, such as the man who believes in peace and love, but has to go to war and kill without reservation. Another example is the inability to appreciate those faults in ourselves which are so obvious to us in other people.

Examples in maladjustment: Dissociation is the basis for many of the most severe symptoms of mental disease. It is shown in automatic movements, in sleep walking, in fugues, in multiple personalities, as well as in all delusions, hallucinations, and illusions. One part of the personality does not know what the other part of the personality does, or perhaps more often disclaims the credit for the behavior of the other part.

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Tuberculosis is responsible each year for the death of more than 2500 children under fifteen years of age in the United States.—Bulletin, The National Tuberculosis Association.

BACILLARY DYSENTERY

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Newton, Kansas

An epidemic of bacillary dysentery which occurred in Newton, Kansas, in September, 1942, was very serious from a public health standpoint because of the type of contamination, its method of spread, and the number of people endangered. A survey made under the direction of the state epidemiologist, Dr. C. H. Kinnaman, established the presence of approximately 3,000 cases in a city of 11,000 inhabitants. This figure is considered conservative. Most of the physicians who dealt with the epidemic placed the number involved much higher. Many believe that fifty per cent or more of the population were affected.

Beginning on September 2, 1942, the water supply of Newton began to be polluted. This pollution of the water distribution system had its origin from a Mexican village situated in the south western part of the city within the city boundaries. There was no pollution in the wells from whence the water was pumped. At this Mexican village there had occurred a plugging of a main sewer with a resultant backing up of a large volume of sewage into some cement pits covering a number of frost-proof water valves which were in a faulty condition. The city of Newton at this time was installing a new fourteen inch water main in the immediate vicinity. The opening of this new, empty water main produced a marked lowering of water pressure and allowed the backing up sewage under a high head to flow into the new main serving the city of Newton with water. A heavy contamination and pollution thus occurred, resulting in a city-wide distribution through the water system.

On September 5, physicians became aware that an intestinal infection was wide-spread and was beginning to assume the proportions of an epidemic. So general was its distribution in the city that the water supply was put under suspicion. Questioning and investigation by physicians of many cases soon revealed that the distribution had no relation to the milk supply, and the dairies which were well regulated were absolved from being the cause. There had been no recent large public gatherings where food was served which would explain the cause. Eating establishments were also eliminated as the cause, as large numbers of patients had not been in restaurants. People had already been advised to boil their water. Most unfortunately the citizens were given a false sense of security by press stories in the city's only newspaper that the water supply was safe. A story on September 11, stated: "The water is pure

and healthful, there are no open mains, no seepage into the distribution system, and no chance of contamination." The very reverse, in fact, was true.

September 10, marked the high point of the epidemic. Physicians were swamped with demands for care. Personnel of several business establishments were so affected that they had to suspend business activities. More than 610 cases occurred on September 10. On September 12, the Kansas State Board of Health was notified and on the following day a corps of health workers arrived. A laboratory was set up and an intensive search for the cause of the epidemic begun. Preliminary tests showed the water supply was highly contaminated. Engineers soon discovered the source of the pollution described above. Chlorination of the water supply was begun immediately and printed warnings were issued telling the people the nature of the epidemic and warned them to boil all the water used. Only pasteurized milk was allowed to be sold as some of the dairies used the polluted water. Following the elimination of the source of contamination and the heavy chlorination of the water together with washing out water mains and dead ends, the water was again declared safe for drinking on September 21. Chlorination has been continued indefinitely.

SYMPTOMS

The symptoms of the infection consisted of severe cramping pains in the abdomen, nausea and vomiting, frequent and painful bowel movements often terminating with the passage of blood, fever, dizziness, and exhaustion. These symptoms lasted from several days to a week and recurrences were common in untreated cases. Many remedies including all those commonly used for the diarrheas were employed, but in the opinion of this writer, none was more efficacious in the prompt control of the infection than sulfathiazole. All of the various sulfa preparations including the slower acting ones such as sulfasuxidine and sulfaguanidine were used, however, sulfathiazole used in connection with bismuth and kaolin mixtures in combination with the opiates to relieve pain gave very efficient results. The usual course was to administer two grams as the initial dose followed by one gram every four hours. Despite the large number of people involved only two deaths could be attributed to the epidemic. The predominate organism causing these two deaths was the Shigella paradysenteriae of the Flexner group, Hiss strain. The laboratory established by the Kansas State Board of Health released the reports on sixty-seven stool cultures made during the epidemic. In thirty-two of these dysentery bacilli were isolated but not completely identified. In eighteen different stools Shigella paradysenteriae, Hiss strain were isolated and identified. The two deaths were due to this organism. In thirty-two stools organisms resembling the Salmonella group were identified. Agglutination tests and blood cultures provided little definite evidence. Typhoid fever was greatly feared but did not develop. A large number of citizens underwent typhoid immunization.

Following this epidemic an inspection by a plumbing inspector was made in every home and business establishment in Newton, especial attention being directed to faulty installations and cross-connections between the water and sewage distribution systems. To date over 300 of such faulty connections have been found. War priority restrictions have made the immediate correction of many of these faulty installations difficult and in some cases impossible. Until these can be corrected, a potential source of danger to the public health remains. Any sudden lowering or release of the water pressure in the distribution system can be the cause of pollution through these faulty cross-connections. Similar conditions probably exist in many other cities and may be uncovered following competent surveys by plumbing inspectors. The most common faulty installations are the frost-proof valve type of toilet bowl connections. A survey in Newton has disclosed over 200 of such connections. This survey has also disclosed over 100 water jet driven syphon pumps used to elevate water from sumps in basements into sewers.

The Kansas State Board of Health was very efficient in helping the city of Newton in discovering the cause of this epidemic and in adopting measures designed to put an immediate stop to its progress. The physicians and the citizens were also fortunate that the medical profession possessed therapeutic products, particularly the sulfa drugs, which made the control of the disease comparatively easy.

Coccidioidal granuloma in human beings is a chronic, highly fatal fungous disease affecting the lungs, skin, lymph nodes, bones, meninges, the organs of the chest, and other body tissues. In a paper in The Journal of the American Medical Association for July 4 on the incidence of the disease in man and animals, George W. Stiles, M.D., and Charles L. Davis, D.V.M., Denver, warn that, while the disease "has been considered peculiar to California, its appearance both in man and in animals from other localities indicates that the malady is either spreading or has not heretofore been recognized. Coincident with this disease in man, an increase is noted in the number of cases occurring in lower animals. In regions in which man has acquired infection, cattle, dogs, sheep, wild rodents and possibly other animals may harbor the fungus.

"Coccidioidal granuloma appears to be acquired by inhaling spores of the fungus, by cutaneous infection through wounds or rarely through the gastrointestinal route."

MIGRAINE

A REVIEW OF CURRENT OPINION ON ITS PATHOLOGY AND TREATMENT

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Cephalalgias are among the most common if not the most common of human discomforts. Too often they are regarded lightly by the physician and their type, character, duration, periodicity, location, intensity and associated symptoms passed over without adequate consideration and their mechanisms and significance underated.

Headache may always be regarded as a symptom of an underlying condition and the treatment of that condition rather than of the symptom manifested engages our interest. Much has been written on the significance of headaches but I wish to discuss only one form of headache, migraine, perhaps the oldest in point of recorded description. Its causation and underlying pathology has never been fully revealed. Many theories have been advanced that have changed during different epochs in medical history and from a standpoint of actual proven pathology its provocation still remains a matter of theorization. The implications and associated disturbances that accompany this distressing condition have been dealt with fully by modern writers, and types of migraine that have been variously classified as gastric, intestinal, hepatic and provocative have been expounded as theories that might induce a derangement of function of this, that or the other viscera of which the migrainous phenomena is an expression. These have been postulations supported by keen observation and careful analysis but are not capable of being established as facts because of frequent contradictions encountered in the observation of large groups of cases. The treatment of this condition covers a wide range of therapeutic agents all of which in their particular era have been regarded as specific. From the days of phlebotomy, blisters and purgation to our modern scientifically conceived but probably no more effective ministrations, the list of therapeutic agents has borne testimony to our inability to fathom the underlying pathology.

Mechanisms: In order to establish a premise it seems necessary to consider what is accepted as the basic mechanisms of headache. These are assumed to be

1. Pressure on cranial and upper cervical nerves.
2. Traction on or spasm of the basilar vessels.
3. Traction or reduced calibration of venus sinuses.
5. Inflammation in the region of pain sensitive structures.

In considering these mechanisms it will be noted that disagreement as to whether the symptoms produced are due to dilitation or to spasm or contraction of the vascular tree within the cranial vault is the provocative factor. Later, in a brief discussion of treatment, this same diversity of opinion manifests itself in the more recent and generally accepted current therapies.

Primarily, we must exclude the nonmigrainous type of headache and we must arbitrarily establish our own criteria.

Headaches that are classified as mild are usually less severe in their manifestations, not periodic, and their duration is usually much shorter and not associated with the concomitant distresses that accompany those of migraine.

Migraine itself has been classified in numerous groupings very largely associated with concomitant symptoms. In the interest of simplicity as well as clarity, migrainous attacks may be classified as simple or those that occur without a premonitory aura and the type which present premonitory symptoms of flashes of light and other acute visual disturbances just preceding the onset of the migrainous attack. The condition is characterized by a periodically recurring and extremely distressing type of cephalalgia usually unilateral, more common in women and likely to be associated with the menarche though it not infrequently occurs in children before puberty and may continue periodically through life or may abate spontaneously in the fourth or fifth decade.

The etiology like the pathology is indefinite. There is frequently present a neurotic background. Hereditary factors are noted in about seventy per cent of observed cases. Hypertensive states are regarded by some as predisposing. This, however, is vitiated by the fact of its frequent early onset before the age of pubescence and the further fact that it seems to occur about as frequently in hypo as in hypertensive states. It has frequently been regarded as an analogue of epilepsy because of the inherited trends, definite periodicity of attacks and the aura which frequently precedes these.

The purpose of the presentation is intended to merely review past concepts and more particularly recent trends of therapy. The oldest text book reference I have been able to find is Gregory[1] in his "Theory and Practice of Physic" published in 1829 who describes the condition as "a disease sometimes confounded with tic doloureux. It commences with a pain near the inner angle of the orbit at the point of the infra orbital foramen and extending a little way on that side affecting also the eye which becomes

red and is more sensitive to light during the paroxysm. The pain is confined to a small point and is relieved by the pressure of the finger though the integument continues sore after the fit is over. ... Dyspepsia, a decayed tooth, fatigue or catarrh have been its exciting causes; bark, arsenic, a large dose of ether before the fit. I have seen an attack of hemicrania cured by copious bleeding which had resisted all other remedies."

Considering the viewpont of the profession over a century ago the description is fairly clear. Within the past six years there seems to have developed greater unaniminity in the treatment of these conditions—possibly empiric.

Sutherland[2] and Wolff discuss the effects of ergotamine tartrate in its effect on the amplitude of pulsations of the cranial arteries and in particular certain branches of the external carotid. They comment on the similarity to headaches induced by the injection of histamine and consider the pathology in relation to disturbance of circulation of the cerebral branches of the internal carotid, basilar and vertebral arteries with the possible involvement of extracranial and dural branches of the external carotid.

Alvarez[3] discusses a theory advanced by some authorities that the source of the difficulty is in the digestive tract and possibly the liver. This viewpoint no doubt finds its basis in migrainous attacks that are accompanied by severe nausea and vomiting, occasioned by reverse peristalsis. He is of the opinion, however, that such reverse in peristaltic action may be attributed to some sort of stimulus or disturbance traveling down the vagus nerve analogous to sea sickness or Meniere's disease. His experience leads him to believe that migraine is less frequent in patients with diseases of the liver and biliary tract than in those who show no biliary involvement. He considers the condition as a hereditary disorder either of the brain or the sympathetic nerves which supply the blood vessels to certain parts of the brain and points out that certain meningeal blood vessels dilate apparently without disturbance of other vascular components within the skull permitting an increased circulation through certain areas. It is interesting that he calls attention to the ability of some sufferers to temporarily arrest the attacks by pressure over the temporal or carotid vessels, the same observation made by Gregory over 100 years ago. He suggests the use of gynergen one-half to one cc having found this satisfactory in about eighty per cent of his cases either alone or in combination with oxygen. He mentions, however, the unpleasant after-effects of gynergen which is sometimes a contraindication.

Gardner, Mountain and Hines[4] have found that this condition is found in hypertensive states in seventy-nine per cent as against fifteen per cent in the control group and observe that from the total registration at the Mayo Clinic during 1938 the diagnosis of migraine was approximately five times as frequent in those presenting hypertension, occurring in 7.7 per cent.

Hadden[5] discusses the symptomatology dealing primarily with a symptom complex regarded as neuralgia of the occipital nerves presenting unilateral headaches beginning in the occipital region and radiating forward into the supraorbital region of the fifth nerve which must be differentiated from migraine.

Von Storch[6] calls attention to headaches due to histamine injections and those characterized as migraine as to similarity of symptoms and regards the pathology as due to hypotonicity of branches of the internal and external carotids. From a series of experiments he arrives at the conclusion that subjects of chronic headaches are very susceptible to the type of headache produced by histamine.

Morlock and Alvarez[7] comment on the common fallacy that migraine is associated with diseases of the gastro-intestinal tract and from their study of 215 patients concluded that headaches of the migrainous type occurred in only seven per cent of the group as against fourteen per cent of 216 cases presenting other forms of pathology. They call attention to the fact that half of the patients exhibiting impairment of liver function were either completely relieved of their migraine or had fewer and milder attacks after the appearance of jaundice or other symptoms indicative of liver pathology.

Carter[8] directs attention to the factor emphasized by Zimmerman[9] of the extreme danger of the administration of ergotamine tartrate in those presenting previous anginal symptoms.

Alvarez[10] commented on the fact that women suffering from migraine are in most instances relieved of their distress with the onset of menopause, presenting the query "can migraine be cured in women by inducing the menopause?" His opinion is that there is little to justify such a procedure for the cure of migraine, stating that in only six of forty-two cases studied did the induction of a premature menopause effect the attacks favorably. In a few, the headaches were milder but in a large number they became worse following the operation and in three cases the condition appeared for the first time after the induction of the menopause.

Palmer[11] discusses the use of vitamin B therapy and the allergic theory as relates to migraine. However, in his discussion of the use of vitamin B_1 this was associated with the use of oxygen and it would

be impossible to determine whether the favorable results reported were due to the vitamin administration or the oxygen, which is known to be effective in a large number of these cases.

Hydman[12] discusses the incidence of migraine caused by or associated with demonstrable pathologic conditions. He reports a case presenting typical migraine symptoms cured by the removal of a small tumor from the calcarine fissure. Whether this was a true migraine or the result of pressure from the tumor growth may be questioned. Various authors including Alvarez[13] and Hines[18] direct attention to the abdominal symptoms and the fact that they may be more manifest than the headaches and may result in confusion in the differentiation of abdominal pain from that due to intra-abdominal pathology.

Holloran[14] discuses migraine in relation to a pituitary study and arrives at the conclusion that migraine is due to a swelling of the pituitary gland which creates compression of the cavernous sinuses resulting in congestion of the intracranial venous system. He attributes the pain to pressure on the papilla within the walls of the dural sinuses. He feels that the various components of migraine may be attributed to pressure phenomena, having their origin in the nervous structures in and about the cavernous sinuses and sella turcica. He also discusses the analogy between migraine, epilepsy and eclampsia.

Von Storch[15] comments on the complications that may follow the use of ergotamine tartrate, particularly of its continued use over long periods. He gives an extended bibliography and cites forty-two cases found in the literature showing the ill effects following the use of the drug, though none have been reported following its employment in the migraine syndrome. He cites as specific contraindications septic states and obliterative vascular diseases and urges unremitting caution in the use of this agent.

Graham and Wolff[16] discuss the mechanism of migraine headache and the action of ergotamine tartrate. They present extensive charts showing alterations in the amplitude of pulsations in the temporal vessels and express the opinion that these headaches are closely related to the amplitude of pulsations in the external carotids. They attribute the relief experienced from the use of this agent to vasoconstriction of temporal and meningeal arteries and believe the data obtained supports the postulation that head pain of the migrainous type is directly due to distension of vessels within the cranium.

Moffett[17] discusses so-called menstrual migraine and its treatment with small doses of gonadotrophic extract of pregnancy urine. His observations are confined entirely to the incidence of migraine-like attacks associated with the menarche. He reports seventeen cases treated by the method outlined with relief in all cases. He also observed that in only four of eleven cases studied roentgenologically was the sella turcica found normal. He concludes from his studies that these confirm the hypothesis that the paramount factor in the production of menstrual migraine is an ovarin hypofunction perhaps associated with pituitary dysfunction.

Riley[18] on the other hand regards migraine as a disorder of the sympathetic nervous system. He discusses its symptoms and possible pathology, gives considerable space to a discussion of the care of the patient in the intervals between attacks and relies largely on hydrotherapy.

Riley[19] discusses the occurrence of migraine in children. He is of the opinion that eighty per cent of these cases begin in childhood between the ages of ten and twelve but he states these may begin in infancy and cites a series of eight cases seen at the Migraine Clinic of the Neurological Institute of New York in which the age of onset was from two to thirteen years. He discusses the symptoms of onset and typical nature of the manifestations, including nausea, vomiting, vertigo with motor sensory and vaso motor manifestations. He did not note hereditary factors as of great value. He mentioned, however, the prevalence of visual hallucinations that were present in all but one case. Scintillations and scotomata were vivid in some instances and other types of visual disturbance showed people upside down and animals and objects with definite forms, and characters were noted as hallucinatory phenomena. He also discusses at some length the spectacular character of abdominal symptoms in children with migraine and offers a brief discussion of the vascular theory variously characterized as inherited weakness of the blood vessel, neurovascular diathesis or vascular dyspraxia and the continued weakness and irritability of the central nervous system, liability of the neurovegetative and sympathetic-vagotonic imbalance. He postulates that x-ray of the sella of patients suffering from migraine invariably shows an erosion either of the anterior or posterior clinoid with enlargement of the sella and frequent breaking through to the sphenoidal sinus or cranial cavity. Other investigators, however, have failed to confirm this view.

Wolff[20] discusses personality features and reactions of subjects with migraine. This discussion is largely theoretical. His conclusions are based on a psychobiologic study of forty-six subjects with migraine. He is led to the belief that victims of this disorder are so constituted as to be peculiarly prone to the development of pernicious emotional states either sustained or with acute episodic exacerbations.

His discussion brings out numerous philosophical postulations that are interesting but not convincing.

Goltman[21] discusses the mechanism of migraine and the various theories and formulations offered. He directs attention to the postulation of Turenne[22] that migraine resulted from compression of the trifacial nerve, particularly its ophthalmic branch, produced by accumulation of blood in the sinuses principally the cavernous sinus and to Auerbachs theory that the symptom complex might be explained upon a basis of disproportion between the cavity of the skull and the volume of its content due to vasomotor action. He concluded that there is a vasomotor spasm with secondary vasodilitation resulting in edema of the brain and temporary hypersecretion of cerebrospinal fluid. His contribution based on one case is of doubtful value to our understanding of the condition.

O'Sullivan[23] reports the treatment of one thousand attacks of migraine with ergotamine tartrate. She discusses the significance of symptoms as they relate to the administration of this drug having carried on pathologic and electrocardiographic studies on patients who have been under treatment for eighteen months or more. She also studied the blood sugar, blood pressure and kidney functions and has found no pathological changes from the use of the agent and recommends its employment under proper supervision.

Engle and Evanson[24] introduced the use of potassum thiocyanate in the treatment of this condition. They discuss the mechanism of signs and symptoms and emphasize the supposition that attacks begin with vasoconstriction of branches of the carotid vessels. They believe the use of long acting vasodilator substances is indicated. They particularly stress the value of this agent in the treatment of migraine in hypertensive patients. They call attention to its potential dangers and advise frequent tests of blood concentration.

Hines and Eaton[25] also consider the use of this agent in hypertensive cases but they report treatment of a small group of those without hypertension with satisfactory results in about seventy-five per cent.

Recent experimental studies by Kunkel, Ray and Wolff[26] indicate that variations in intracranial pressure cannot always be regarded as the cause of these headaches. This is futher borne out by the fact that many intracranial neoplasms attain considerable size where headache is not an outstanding symptom or noticeably present.

Guttman[27] in a recent article reports excellent results from the use of ergotamine tartrate in the treatment of post puncture headaches.

CONCLUSIONS

It is evident from the above review of current literature that authorities are still far from agreement as to the etiology, pathology or treatment of this condition. Etiology and pathology offer an interesting field for further study. The most widely used therapeutic weapon over the past few years has been ergotamine tartrate, a vasoconstrictor. Its proponents claim success in eighty per cent of patients treated. More recently, other writers have advocated the use of potassium thiocyanate, a vasodilator. They also claim successful results in eighty per cent of cases treated by this method. It would appear therefore that there are several provocative mechanisms responsible for this type of headache or that there is a strong neurotic background that makes the sufferer highly susceptible to suggestion.

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The American Council on Medical Education has announced that due to the speed-up in our medical schools there will be twenty-one thousand physicians graduated in this country during the next three years. This figure is some five thousand higher than that which normally would have obtained before the war. Several of our medical schools have adopted a more or less continuous session, which is being carried out with no sacrifice of educational standards. —The Journal of the Indiana Medical Association.

President's Page

To: The Members of the Kansas Medical Society:

There are some 500 Kansas physicians in the service of our country and for the most part these men represent the very cream of our profession and the men who will be the leaders of Kansas medicine in the future. I hear from many of these young fellows and although they receive the Journal, they still feel that the home boys do not correspond with them, do not make them feel that they are missed. How many letters have you written to the boy who practiced beside you? You are taking care of many of his patients, you know his interests, why not start today and keep up a continual correspondence with that chap. Tell him of the things that are going on around the home town. He will return some day and we should be big enough to see that he returns to his practice, that we will slap him on the back and welcome him, help him re-establish himself into civilian practice.

Much is written about post-war planning and I am wondering if our profession should not begin to make definite plans for this period. To satisfy many of these fellows, we should make available better and more hospitals, laboratories, x-ray facilities and the many adjuncts that will enable us to render a better service to our citizens. To do this, we must interest local people and convince them that we should have these facilities available. The time should soon pass when it is necessary to send many of our patients away from home for medical care. Medical training today prepares its graduates for the readition of a great service to the public and to complete this cycle, we must make properly equipped hospitals available for these physicians.

Many of these physicians will want to spend a few months in intensive study and a movement has already been started in the Kansas Medical Society, as suggested by Dr. Harold Jones of Winfield, for post-graduate study in the Kansas University School of Medicine. It is Dr. Jones' idea that many Kansas physicians will want to make a substantial donation to this fund, which would enable returning physicians to take this post-graduate course, without cost.

Sincerely,

J. L. Lattimore M.D.

President, The Kansas Medical Society

EDITORIAL

THE BLUE CROSS

Organized ten years ago the Blue Cross non-profit hospital plan has won the approval and backing of the American Hospital Association, the physicians of the country, 2,500 community hospitals and 12,000,000 subscribers.

According to the records of the Blue Cross it has been found that one out of every four families will have need of hospital care each year. The other three families share in the cost and in the benefits in the following years.

In Kansas the Blue Cross plan has been a great success. Organized in July, 1942, by an act passed by the 1941 legislature which made such organization legal, on October 1, 1943, the plan had an enrollment of 292 groups of 27,232 members, forty-six participating hospitals in the following Kansas towns and cities: Abilene, Caldwell, Chanute, Colby, Concordia, Dodge City, El Dorado, Emporia, Fort Scott, Garden City, Goodland, Great Bend, Hays, Horton, Hutchinson, Independence, Junction City, Kansas City, Leavenworth, Manhattan, Marysville, McPherson, Neodesha, Newton, Ottawa, Sabetha, Salina, Scott City, Stafford, Sterling, Syracuse, Topeka, Wichita and Winfield. Mr. Sam J. Barham, the executive director, formerly located in North Carolina and New York City, came out from the Boston office to organize and develop the Kansas hospital service. Mr. Barham established the state offices in the Crawford Building in Topeka.

Assisting Mr. Barham in the Kansas cooperation are the following non-paid officers: Mr. John R. Stone of Topeka, president; Dr. John L. Lattimore of Topeka, vice-president; Mr. H. J. Andres of Newton, vice-president; Mr. Warren M. Crosby of Topeka, secretary, and Mr. Laird Dean of Topeka, treasurer. The directors are: Dr. C. D. Blake of Hays, Dr. H. O. Bullock of Independence, Mr. C. C. Cogswell of Topeka, Rev. John Warren Day of Topeka, Rev. E. J. Duchene of Concordia, Dr. L. C. Edmonds of Horton, Sister Mary Fidelis, R.N. of Salina, Dr. Charles C. Hawkes of Winfield, Zillah Leasure, R.N. of Salina, Dean W. Malott of Lawrence, Mr. J. C. Mohler of Topeka, Dr. J. H. A. Peck of St. Francis, Dr. Charles Rombold of Wichita, Mr. Bernard L. Sheridan of Paola, Dr. M. G. Sloo of Topeka, Dr. Leo Turgeon of Topeka, Mr. O. O. Wolf of Manhattan, and Mr. C. O. Wright of Topeka.

Payment rates for the plan vary with the hospital cost in that part of the country in which the group is organized, the New York rate being greater than that in other parts of the country. In Kansas the rate is sixty-five cents per month for individual members and $1.30 per month for employees with families. All of the thirty-five states and the seventy-seven different plans have variations in the costs and operations, however, the enrollment is universally by group such as farm bureaus, bar associations, employment concerns and not through individual application as in other types of insurance.

In return the members of the Blue Cross receive thirty days of hospital care annually for accommodations costing up to $4.00 per day. More expensive rooms may be secured by the individuals who desire to pay the additional cost over the fixed amount. Routine laboratory examinations, ordinary drugs, surgical dressings, plaster casts, the use of the operating room as often as is necessary, the use of the delivery room (special requirements are in the plan for delivery service), anesthesia materials and nursing care are all provided in the payments.

It can well be seen that the public has accepted with hearty approval this very American type of hospital plan which solves the emergency problem of hospital expense for the average income family, which so often upsets the budget and makes frantic demands for an emergency loan necessary. The plan has also bettered the financial condition of many participating hospitals by the prompt payment of hospital bills by Blue Cross members.

The Wagner bill has recently been introduced in Congress with a proposed twelve per cent salary deduction which will regiment physicians, hospitals, medical schools and nurses and throw this fine American pay-as-you-go hospital plan in the discard. An article in the October 2, Saturday Evening Post entitled, "This Cross Is Blue," gives a fine summary of the effect this type of legislation will have on this and similar insurance plans. If you and your patients have not read the article, please do so at once.

I AM AN AMERICAN

(Reprinted from an Editorial which appeared in the New York Times)

"I am an American. I say those words with gratitude, faith and pride. Gratitude to the generations of hard-working and God-fearing men and women who came to this New World to make a home for freedom. Faith that the democracy they built will never die. Pride that my chance has come to show that I can defend their labor worthily.

"I am an American. A little of every race and every nation went into the melting-pot that poured me. Europe is there, and a fragment of Africa, and some of Asia. I am all races and all tongues, all colors and all creeds. But I am an American because I have dreamt the dream of the founders of this

democracy, and because I have a share in every act of faith that made their dream come true. Lincoln at Gettysburg spoke for me. Valley Forge was my winter too. I knew Tom Paine and the Raleigh Tavern and the village green at Lexington. Old Hickory talked my language. Ethan Allen thundered in my name. Jefferson writing his statute for religious liberty wanted me to have a chance to worship God in my own way. The Pilgrim Fathers gave me a stubborn hope. Appomattox taught me charity. Boone showed me the Western trails. The pioneers who climbed the hills and crossed the great valleys found a country broad enough for men of every race to live in self-respect and friendship with their neighbors. It is not race or creed or color that makes an American. It is a decent regard for the rights of man and a healthy love of freedom.

"I am an American. My home is a continent between two seas. On this continent I have helped to build the only way of life which I believe to be worth living. It is a friendly way of life, with room for the opinions of the man across the street. It is an honorable way of life, asking no compromise with convictions. It is an eager way of life, forever pressing on to new experiments, new trials, new errors, another start and fresh achievement. It is a successful way of life, with the highest standard of material well-being and the broadest basis of popular education that the world has ever known. It is an alert way of life, on guard day and night against impairment of the rights that a free people cherish: the right to think for themselves and to vote as they please, to choose their own church, to read a free press, to name their own leaders in a free election; the right to discuss, to disagree, to try new roads, to make mistakes and to correct them; the right to be secure against the exercise of arbitrary power; the right to live their lives in their own way.

"I am an American. I shall fight to defend my democracy against any combination of enemies that can be brought against it. I shall fight. And I shall win. For the reserves of moral strength as well as physical power are on my side. What is the meaning of the story of my country, if it does not teach me Valley Forge, if it does not rule out the word surrender? Lincoln and Jefferson stand with me in this fight. Washington still rides before my armies. Every truth I learned at my father's knee about the blessings of American freedom and independence has prepared me for this day and hour. Every humane and understanding act of statesmanship that made my people a united nation now arms for this test of strength. Every faith I hold and every liberty I cherish calls me into action to defend my own.

"Into this battle I go willingly, with gratitude to the men and women who gave me what I have, with faith in what they built, with pride in my own purpose.—Mahoning County Medical Society, Ohio.

TUBERCULOSIS CONTROL

THE FAMILY PHYSICIAN HOLDS THE ACE CARD

Increasingly, family physicians may expect to see numbers of men and women who have been told that they have tuberculosis and referred to their own doctors for advice, treatment or further study.

These cases are the product of widespread and ambitious programs of mass chest x-raying in Army and Navy inductions, in industrial plants, in colleges and among other groups. In Massachusetts the Army alone has rejected for military service more than 2,000 men because of actual or suspected pulmonary tuberculosis.

A system has been set up in Massachusetts that works very well and that has its counterpart, with various modifications, in many areas of the United States. The names and addresses of rejectees are forwarded from the examining station to the Department of Public Health. The state district health officer, working through the local board of health, pursues a follow-up that attempts to secure answers to important questions on each such rejectee.

Has the patient been x-rayed again? If so, by whom? What were the findings? Was the diagnosis of tuberculosis confirmed? If so, has the case been reported? What further study or treatment has been recommended, and is it being carried out? If the diagnosis was confirmed, how many household contacts have been x-rayed and what are the names of any found to have tuberculosis?

In the case of industrial surveys, with the patient's cooperation a roentgenographic report is sent by the Department of Public Health to the designated family physician. Only in instances where the patient says he has no regular physician or does not intend to consult one is attendance at a tuberculosis clinic suggested as an alternative to private care.

Cases reaching the doctor through these channels of reference fall into several groups:

1. Active tuberculosis: This is the simplest, perhaps, as these people need prompt sanatorium care, possibly collapse therapy as well. Repetition of the x-ray may be unnecessary, if the diagnosis is clear-cut. Three necessary steps include: reporting the case, arranging for admission to a sanatorium and

examining by x-ray all household contacts. It should be emphasized, however, that diagnosing and reporting tuberculosis solely on the basis of x-ray evidence can result in serious errors.

2. Suspected tuberculosis: In the light of an x-ray opinion this usually means that the roentgenologist has seen a small hazy or infiltrative shadow but is not sure enough of its presence or significance to label it pulmonary tuberculosis. Invariably these patients need another film. Improved technic may be sufficient to settle the question. Disappearance of the suspicious lesion may indicate it was of acute pneumonitic origin. Generally, however, this new film—since the original is rarely available — becomes the first of a progress series by means of which a suspicious area is to be observed. Symptoms and physical signs are more likely to be lacking than elicited in such early cases. Exhaustive clinical and laboratory study is indicated. While a sputum or gastric sediment containing tubercle bacilli is sometimes found and is clinching evidence of tuberculosis when confirmed by culture or animal inoculation, such things as a shift in the differential leukocyte count, accelerated red blood cell sedimentation rate and slight rise in temperature late in the day are of confirmatory value only, as they are not specific for tuberculosis, nor is their absence proof that lesion is either non-tuberculous or inactive. Most valuable aid in following and evaluating all such cases is the procedure of serial x-ray filming at appropriate intervals.

3. Inactive or healed tuberculosis: Most of the measures advocated for Group 2 above apply with equal force to this third category. An initial film is always advisable and full study and periodic filming is essential whenever there is the slightest doubt about the true status of the lesion, especially in young subjects or where a lesion is beyond the minimal limits. It should be recalled that the classification of minimal, moderately advanced or far advanced refers solely to the extent of the involvement, not to the activity of the process. Physicians should acquaint themselves with the groupings of patients according to clinical status as set forth in "Diagnostic Standards," published by the National Tuberculosis Association. However, it must be realized that no such exact classification as apparently cured, arrested, apparently arrested, inactive and active can or should be attempted from examination of a single x-ray film. Even to try to grade cases as active or inactive on such a basis leads to many errors, although the visualization of cavities allows no question that activity is present.

4. Primary phase tuberculosis: This diagnosis is common but clinically not important in adults. Rarely is it active, usually being of the calcified primary complex type. Nevertheless, it is essential that the physician make certain his case is clearly in this category before so dismissing it.

5. Pleurisy with effusion: This is rarely discovered in mass surveys. Evidence of old attacks commonly shows up, but means little if none has occurred within five years.

6. Non-tuberculosis conditions: These are fairly frequently encountered. A few may be mistaken for tuberculosis, but careful study will usually reveal the true nature of shadows caused by such conditions as atypical pneumonia, bronchiectasis, atelectasis, suppurative lung abscess, lymphoma, sarcoid, cystic disease of the lung and primary or metastic lung cancer. Emphysema, generalized pulmonary fibrosis and spontaneous pneumothorax should not be too difficult of recognition. Abnormal cardiac silhouettes often give the clue to unsuspected heart lesions, while developmental anomalies of visceral or skeletal nature are of passing interest.

* * *

It should be remembered that tuberculosis is a disease of adults and is seldom found in children after infancy and before adolescence; that its prevalence tends to increase with age from adolescence on; that the frequency of inactive disease also increases with age; that the majority of reinfection-type lesions found in young persons are unstable; and that many lesions in older persons are a greater source of danger to their associates than to themselves.

It is highly important that private practitioners make the early diagnosis that confers greatest benefit on the patient, his family and the community. Unfortunately, sanatorium records show that the proportion of far-advanced cases admitted for the first time has not yet declined, nor has the proportion of minimal cases risen, in spite of the wider use of x-ray. Surveys cannot reach everyone; the public must be educated to consult a physician earlier, and the physician must be on the alert.

New case-finding methods have initiated a large scale attack on unsuspected tuberculosis among apparently healthy people. It is the duty as well as the opportunity of the family physician to carry it through. — Roentgenographic Surveys for Tuberculosis in Massachusetts and Their Importance to the Physician, Philip E. Sartwell, M.D., New England Journal of Medicine, June 3, 1943.

During the Civil War, life insurance paid American families about $7,000 daily in policy benefits; during the Spanish-American War about $400,000 daily; during World War I about $1,600,000 daily; and today $6,500,000 daily.—Pennsylvania Medical Journal.

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MEN IN SERVICE

We hope that the "Men in Service" news will be as interesting to you as we have been told similar columns have become in other medical periodicals. There is one drawback, however, if you do not send in your material about our service men much of it will never be printed. We very much wish to thank those who have sent in information for this month's column. Keep the letters and news coming to the Journal office. We cannot publish any information on military, troop or ship movement, but personal news and letters of camp life are interesting to those at home as well as those in other camps or countries. Please send us more news of "Men in Service." —The Editor.

— — —

Capt. Thomas P. Butcher of Emporia was recently placed in charge of the department of surgery at Key Field in Meridian, Mississippi. Capt. Butcher is at the present time on leave to attend a post graduate course in surgery at Columbia University in New York but will return to Key Field following completion of the work.

We have been recently informed as follows:

"I was astonished to see in this months Journal that I had been in the Army and was now back home practicing again. I have never been in the Army or away from Emporia. I wonder if they have confused me with my son, Dr. Franklin W. Foncannon, who is a captain in the medical corps with the Army Air Force in the South Pacific. He is still there and has not been relieved from duty. I want to correct this mistake as I do not want to receive credit for Army service when I have not been in the Army." Frank Foncannon, M.D.

Dr. John B. Nanninga writes to tell us that his nephew, Lt. T. R. Nanninga formerly of Abilene, was not listed as in the men in the service from Kansas. Dr. Nanninga graduated from the University of Kansas Medical School in 1941 and interned at the University of Kansas Hospital. He is now stationed at Camp Barkley, Texas. Dickinson County and Abilene where his parents live would get the credit for another man in service.

Mrs. Muller writes us to change the Journal address for Lt. Samuel B. Muller of Pittsburg who is with the United States Navy and who will henceforth receive his Journals at a San Francisco Fleet Post Office.

Dr. Marion Trueheart of Sterling has informed us that Major A. A. Sprong formerly of Sterling and recently stationed at Winfield has been doing post graduate work in internal medicine at the Mayo Clinic.

Captain Preston E. Beauchamp of Sterling is now stationed at Lubbock, Texas.

Capt. Thomas C. Hurst of Wichita has recently completed a course on anesthesia at the Mayo Clinic in Rochester, Minnesota. Captain Hurst is now stationed at Fort Leonard Wood, Missouri. Lt. H. H. Hyndman also of Wichita is now attending the Mayo course in anesthesia.

The Sedgwick County Medical Bulletin recently announced that Lt. Sherburn McLeod is recuperating from tropical fever in a west coast hospital, contracted while on duty in the South Pacific area.

Lt. Clarence W. Erickson of Pittsburg has recently been promoted to the rank of Captain, and is stationed at Camp Crowder, Missouri.

Major H. W. Palmer of Wichita writes to the Bulletin: "The Aussies have a slang all their own, of course many terms are identical with English ones, as Bartlett can tell you. For example, a streetcar is a tram, an elevator a lift, a railroad a railway, a truck a lorry, and of course many more . . . They drive on the left hand side of the road as do the English. Please pardon my penmanship, as I have been trying to listen to National Barn Dance (re-broadcasted over Aussie stations). American programs, such as Fibber McGee, Bob Hope, Bing Crosby, Stage Door Canteen and Command Performance, are greatly appreciated by all of us. . . . We are at present undergoing our winter, July being the coldest month. It gets quite cold at night but the sun comes out bright during the day and midday one can go about comfortably without a coat."

Lt. Comdr. Harvey E. Reitz of Wichita has recently returned to the states following two years service in the South Pacific. He is stationed at Helena, Montana.

We hope Lt. Letteer Lewis will forgive our quoting from his recent letter which states that it is not for publication: "Will you please see that the Journal is sent to me. These Southwest Pacific Islands are beautiful. We have excellent living quarters, electricity, running water, showers. For recreation we have a good baseball diamond, two volley ball courts, a basket ball court, ping pong tables, horseshoe grounds, and equipment to go with them. We have a swell beach and the water is perfectly clear blue and warm and makes good swimming. So you see we do not lack for recreational facilities. I would be interested in hearing of anything of current interest in the Kansas State Medical Society." Lt. Lewis is a flight surgeon formerly of McPherson.

Capt. Charles T. Moran of Arkansas City is now stationed at Kelley Field, Texas.

Capt. C. G. Davis of Kansas City has been transferred from Abilene, Texas to Brownwood, Texas.

Major William M. Brewer of Hays is now stationed at Camp Gruber, Oklahoma.

Lt. Col. E. K. Lawrence of Hiawatha is now stationed in New Orleans, Louisiana.

From Lt. Comdr. Harold O. Closson formerly of Ashland we have the following letter: "A year or more ago at the Topeka state meeting I read a paper on 'Relapsing



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THE CHOICE of a sedative for the sleepless patient is not alone dependent upon the rapidity of its action, but also upon the duration of action and how the patient feels when he awakens.

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Fever' which was later published in the Journal. I have been asked to give a paper on the same subject here and would like very much to have a copy of the Journal in which my paper was printed". Lt. Comdr. Closson is stationed at the United States Naval Hospital on Treasure Island in San Francisco.

Capt. Willis H. McKean of Kansas City is now stationed at the Valley Forge General Hospital at Phoenixville, Pennsylvania.

Capt. I. R. Morrison of Atchison is now stationed at Monroe, Louisiana.

Major D. R. Wilson of Mound Valley is in the office of the Ohio Selective Service System in Columbus, Ohio.

According to recent newspaper reports 50,000 copies of the book "Horse and Buggy Doctor" by Arthur Hertzler of Halstead have been ordered by the United States Army for distribution to various camp libraries. Another good example of a home-front doctor doing his bit for the boys in the service.

We have been informed that Lt. Charles Pokorny formerly of Attica is now attached as surgeon with the first motion picture unit. The unit is located in the old Hal Roach studios in Culver City, California and is making training films for the Air Corps. The unit also trains combat camera units who fly in the bombers taking pictures of action on the fighting fronts.

Dr. L. L. Huntley of Larned has recently reported for duty with the rank of Captain.

The September 18 issue of the Journal of the American Medical Association carried a picture on page 155 of the personnel of a hospital in the South Pacific in which two Kansas members are serving. Lt. Comdr. B. I. Krehbiel of Topeka and Lt. Comdr. James S. Hibbard of Wichita are members of the Navy hospital unit which was celebrating its first year of oversea service. The article accompaning the picture gave a brief description of each member of the unit.

Capt. David E. Gray of Topeka, son of the late Dr. A. D. Gray, has recently been in Topeka on furlough. Captain Gray is stationed at Breckenridge, Kentucky.

Lt. Wayne O. Wallace of Atchison is now at the University of Tennessee, in Memphis.

Lt. Earl Martin of Oskaloosa has been promoted to the rank of captain and is at the present time on Army maneuvers.

When you have made an observation of value or reached a conclusion concerning the unusual, publish it. Avoid carrying unpublished knowledge to the grave! The three great foes of the physician are ignorance which is sin; apathy, which is the world; and vice which is the devil.—Sir William Osler.

NEWS NOTES

APPOINTMENT

Governor Andrew Schoeppel announced the appointment of Dr. George R. Dean of McPherson, as the new member of the Kansas State Board of Medical Registration and Examination as of October 6.

Dr. Dean was appointed to fill the unexpired term of office of Dr. O. L. Cox of Iola, who died recently. Dr. Dean will serve as a board member until April 30, 1946.

COURSE ON MEDICAL PROTOZOOLOGY FOR LABORATORY TECHNICIANS

The University of Kansas Extension Division had so many requests following the post graduate course for physicians on "Tropical Medicine" that a new short course on "Medical Protozoology" has been instituted by that department for laboratory technicians in the state. The course will be held the week of October 27 to November 2 which is the close of the fall term at the University of Kansas and makes the parasitology laboratory available for use of the enrollees.

As the enrollment is limited to thirty it will be necessary for those physicians who desire that their laboratory technicians enrolled in the course do so at once. The course will offer actual work in the diagnosis and technique of tropical diseases and those enrolled will work personally with the actual clinical material in the preparation of slides and diagnosis of parasites. The laboratory has a large variety of pertinent clinical material all of which will be available for the course.

Miss Mary E. Larson, Assistant Professor of Zoology of the University of Kansas will conduct the course which will be composed of study and laboratory work on malaria and its three species; trypanosoma and leishmania (the sleeping sickness of Africa and South America); endamoeba histolytica, intestinal flagellates of man and intestinal ciliates and sporozoa. All sessions of the course will be held in Snow Hall on the campus of the University of Kansas, the morning classes being held from 9:00 to 12:00 and the afternoon from 2:00 to 5:00, a fee of $15.00 is charged to cover the cost of the course.

BLAST AT HEALTH PLAN

Was the headline of an article in the September 23 issue of the Kansas City Times which quoted an editorial published in the September issue of the Journal which was entitled "Bureauracy for Medicine."

The introductory paragraph has the following to say: "Kansas medical men today took a running jump at the Wagner health bill now before Congress. The Journal of the Kansas Medical Society, the official organ of the oldest corporation in the state to which most medical men belong declared the bill to be the 'most vicious piece of legislation ever to be proposed in Congress'. The Journal, issued by a board of physicians and surgeons headed by Dr. W. M. Mills, Topeka, said." and the editorial in its entirety was quoted.

No doubt the news story in the Times will be copied in many newspapers and read by thousands. It is hoped that in this way a broader understanding of the scope of



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the bill will open the eyes of the public to the faults that such a measure will encompass in nation wide medical service with its added tax burden.

NEW MEMBERS CMAB ADVISORY COMMITTEE

The Board of Trustees of the American Medical Association at its official meeting held in Chicago on September 17 announced the following two new members have been selected to serve on the advisory committee of the Cooperative Medical Advertising Bureau: Dr. Stanley B. Weld, editor-in-chief of the Connecticut State Medical Journal and Dr. E. M. Shanklin, editor of the Journal of the Indiana State Medical Association.

The advisory committee had previously consisted of three members: Dr. Walter E. Vest, editor of the West Virginia Medical Journal, Mr. W. C. Braun, manager of the advertising department and Dr. Olin West, secretary and general manager of the Association.

The request for two additional medical-editor board members was made at the meeting of the editors and business managers which was held in Chicago on June 5. The votes were cast by the editors of all Journals cooperating with the bureau and according to news received from Dr. West a meeting of the enlarged committee is scheduled for the near future.

SECRETARIES AND EDITORS MEETING

Announcement has been received that the annual conference of secretaries and editors of Constituent State Medical Societies will be held in Chicago on November 19 and 20.

The program has not as yet been announced but will consist of matters of interest to the members. Dr. W. M. Mills of Topeka, editor of the Journal and Mr. Robert Brooks, executive secretary of the Society will attend the meeting.

MEDICAL BOARD MEETINGS

The next examination of the Kansas State Board of Medical Registration and Examination will be held in Kansas City, Kansas, at the Chamber of Commerce on Wednesday and Thursday, February 2-3, 1944. This examination will be held for the convenience of the graduating class of the School of Medicine, University of Kansas, who will receive their diplomas on January 31, 1944.

The regular meeting of the Board as per statute will be held in Topeka at the Kansan Hotel on December 14, 1943, for the transaction of business.

TROPICAL MEDICINE LECTURE

According to word received from E. R. Squibb and Sons, their medical director from Brazil, Dr. Olympio da Fonseca, Jr., has arrived in the United States for a series of lectures to the faculties and students of medical schools throughout the country and will lecture at the University of Kansas School of Medicine on November 5, at the University of Oklahoma School of Medicine on November 3, and at the University of Nebraska College of Medicine on November 8.

Dr. da Fronseca, whose invitation to lecture to the schools of the United States came from the Pan American Sanitary Bureau, is a professor of the National School of Medicine of the University of Brazil, connected with the medical center of Ceara and the department of health of that state as well as the author of a book on "Medical Parasitology."

In his discussion of tropical medicine, Dr. da Fronseca will give special emphasis to the subjects of malaria, African sleeping sickness, amebic dysentary and ring worm infection.

NEW FEE SCHEDULE FOR MATERIAL AND INFANT CARE PLAN

The Kansas State Board of Health recently released a new fee schedule for maternal and infant care in the program for service men's dependents which is as follows:

MATERNITY CARE

Complete care	$35.00
Delivery and postpartum care	25.00
Prenatal care only	10.00

SICK INFANT CARE

First visit—	
Home call	$ 4.00
Office or hospital call	2.00
Additional visits—	
Home call	2.00
Office or hospital calls	2.00
Maximum payment—	
First week of illness	10.00
For subsequent week	5.00

Consultation $10.00 plus mileage—
($10.00 to $35.00)
(List of consultants yet to be prepared.)

SPECIAL FEES

Major surgery not to exceed	$35.00
Anesthesia by physician	7.50
Assistant surgeon	7.50
Circumcision (necessary cases only)	7.50

HOSPITALS

Original authorization not to exceed fourteen days at $4.50
Extension of hospitalization on application of physician (as long as needed) same rate.
Emergency hospitalization any time during pregnancy or six weeks thereafter.

HARD OF HEARING WEEK

The seventeenth national Hearing week will be observed throughout the United States and Canada on October 24-30.

The American Society for the Hard of Hearing in Washington, D. C. and the 121 chapters throughout the states will participate in observance and the purpose of the week is to emphasize the value of hearing and the means of conserving it.

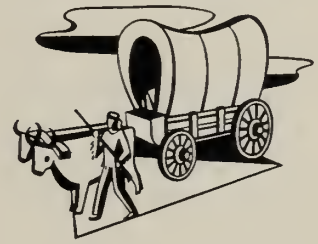
FEDERAL-STATE CIVILIAN REHABILITATION PROGRAM

According to Mr. Paul V. McNutt a new office of Vocational Rehabilitation has been established in connection with the office of the Federal Security Agency to administer the civilian vocational rehabilitation program which has been provided under the Barden-LaFollette Act passed in July 1943.

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Today, Kansas faces a new, greater frontier that combines the best of all the others. It is a frontier of chemistry and science, the production of goods through the combination of Kansas farm and mineral products.

It also is a frontier that can be interpreted in terms of the growth of the smaller Kansas communities. It CAN be—if those communities plan NOW.

Efforts made today will mean that Your town will have something with which to attract returning servicemen and returning war workers. It can mean an increased population . . . and that means a greater farm produce market with greater wealth for the entire area.



It will pay to know today what you want to do tomorrow. Contact the Kansas Industrial Development Commission for information on what your town can do about making plans for tomorrow.

The Kansas Industrial Development Commission

801 HARRISON TOPEKA, KANSAS

Michael J. Shortley is the new director of Vocational Rehabilitation and John A. Kratz is the associate director.

The expansion of this program will contribute to the war effort by facilitating reemployment of the physically handicapped through restoration and training for employment. "Until now," Mr. McNutt says, "the program did not provide for remedial treatment, though frequently relatively simple surgery would materially decrease the physical handicap or even remove or fully compensate for it. The new law makes Federal money available for this purpose, as well as for job training."

Congress has recently authorized the Veterans Administration to provide vocational rehabilitation at Federal expense to discharged veterans of the present war who have service-connected handicaps. The new program will provide rehabilitation for other groups of handicapped individuals not receiving service under the veterans plan. The new legislation meets a special wartime need by providing for the rehabilitation of persons injured in nonmilitary war services. War disabled civilians covered by this provision include those incapacitated while serving as an unpaid volunteer in the Aircraft Warning Service. the Civil Air Patrol, or in protective service under the United States Citizens Defense Corps; or as a registered trainee taking training for such protective service, or as an officer or member of the crew of a vessel owned or chartered by the Maritime Commission or the War Shipping Administration.

As a war measure, the federal government will pay the expense incurred by the states in the rehabilitation of these war disabled civilians. Under the new statute federal grants also will cover the entire administrative cost of approved state vocational rehabilitation programs and half the expense for rehabilitating individuals other than war disabled civilians. State Boards of Vocational Education are designed as the agencies for the administration, supervision and control of state programs, except that administration of rehabilitation for the adult blind is committed to state blind commissions or similar agencies where such bodies have the necessary authority under state law.

Mr. McNutt points out that the present program is based on more than twenty years of experience, as Federal grants to states for vocational rehabilitation have been authorized by Congress since 1920.

WOMAN MEDICAL CORPS CAPTAIN TO FORT RILEY

Recently announcement has been made that one of the first women doctors to be commissioned in the Medical Corps of the Army has reported for duty at Fort Riley Station hospital. Dr. Jessie D. Read, formerly of Westfield, New Jersey, now a Captain in the Army Medical Corps is one of the first group of thirteen women to receive Army commissions, other than those granted to women in the "WACs."

Captain Read, an obstetrician with twelve years of civilian practice, a member of the American Board of Obstetrics and Gynecology, was graduated from Long Island College of Medicine of Brooklyn, New York in 1928. She interned at the New York Infirmary for Women and Children and was a member of the staff of the Bellvue Hospital and Dispensary of New York, assistant obstetrician in the Hospital of St. Barnabas for Women and Children of Newark, and resident of the Margaret Hague

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October 18, 19, 20, 21, 1943

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DR. GRAYSON L. CARROLL, Urology, St. Louis University School of Medicine.

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DR. CLINTON W. LANE, Dermotology, Woshington University School of Medicine.

DR. HARRY E. MOCK, Surgery, Northwestern University School of Medicine.

DR. THOMAS G. ORR, Surgery, University of Konsos School of Medicine.

DR. LOUIS E. PHANEUF, Gynecology, Tufts College Medicol School.

DR. ROBERT D. SCHROCK, Orthopedic Surgery, University of Nebrosko School of Medicine

DR. JOHN A. TOOMEY, Pediotrics, Western Reserve University School of Medicine

DR. W. LIKELY SIMPSON, Otoloryngology, University of Tennessee School of Medicine.

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Maternity Hospital in Jersey City, New Jersey. She has practiced in Jersey City and in Westfield, New Jersey. On being commissioned in the Medical Corps she was first stationed at Fort Des Moines and then transferred to Fort Riley in September.

KANSAS TUBERCULOSIS MEETING

The Kansas State Tuberculosis and Health Association annual meeting was held in Topeka on September 1 and 2, 1943.

Members of the Society who appeared on the program were as follows: Dr. C. H. Lerrigo, executive secretary of the association who spoke on "Early Diagnosis Campaign"; Dr. F. C. Beelman, executive secretary of the Kansas State Board of Health who presided at the general assembly; Dr. Fred Mayes and Dr. H. L. Hiebert of the Board of Health assisted in the program.

NEW CHILDREN'S HOSPITAL IN MEXICO CITY

The first children's hospital built by the Government of Mexico and the second building in the new medical center was dedicated in May 1943. The building is modernistic in style, of concrete, with six floors and a capacity of 550 beds for children of all ages up to fourteen years.

One unit has been especially designed for premature infants care. There are also out-patients clinics, laboratories for special diagnostic service, in-patient facilities for pediatrics, orthopedic surgery, general surgery, otolarynology, ophthalmology, neurology and dermatology as well as physiotherapy, occupational therapy, educational and social service.

The charges of the hospital are moderate with treatment free for those whose families are unable to pay. Hospital Infantil will be used as a teaching hospital for the medical school of the National University and has lecture rooms, classrooms and student laboratories located in the building.

Dr. Juan Farill, an orthopedic surgeon of Mexico has been designated chief of the orthopedic service of the hospital. There is a full-time staff of roentgenologists, pathologists, bacteriologists, and physical therapists in the hospital.

OSTEOPATHS

The Kansas State Board of Medical Registration and Examination filed an injunction in the district court of Dickenson County on September 7, restraining L. A. Moore, osteopath, of Herington, from the practice of medicine, surgery and drug therapy, in the state of Kansas.

The suit was brought on behalf of the state by Mr. Dean McIntire, County Attorney of Dickinson County and Mr. Floyd Erickson, attorney for the state Board.

Moore has thirty days in which to file his answer to the allegations of the Board.

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FRACTURES & TRAUMATIC SURGERY—Courses to be announced in January.
GYNECOLOGY—Two Weeks Intensive course starting February 7th. One Week Personal Course in Vaginal Approach to Pelvic Surgery starting November 1st. Clinical and Diagnostic Courses.
OBSTETRICS — Two Weeks Intensive Course starting February 21st.
ANESTHESIA—One Week Course in Continuous Caudal Anesthesia for Obstetrics.
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reduced meat supply of the family. Every year in November and December during the rabbit hunting season the number of cases of tularemia greatly increase.

As a precautionary measure the housewife, the hunter and the market man who handle or dress the game should all wear rubber gloves while skinning or dressing rabbits. Wash the hands carefully with lots of soap and water whenever handling rabbits and in case of scratch or abrasion, disenfect the wound at once. Even in handling only the fur of the rabbits care should be used and the hands washed well.

Tularemia is primarily a disease of wild life and contact with infected animals is necessary for contraction of the disease. Hunters should avoid shooting sluggish rabbits or those that refuse to run as these are probably sick.

RHODE ISLAND JOURNAL

The August issue of the Rhode Island Journal came to the desk with a new format, very attractive indeed in its new white cover and red and black lettering. Inside, the Journal has introduced a few new departments with interesting heads. All but a few of the advertising pages are carried on the left with the departments on the right hand pages. Congratulations on an interesting new style in medical journal typography.

MEMBERS

Kansas members taking active part in the program of the Kansas City Southwest Clinical Society meeting which was held on October 4-6 are as follows: Dr. Lewis G. Allen, Dr. Fred E. Angle, Dr. Thomas G. Orr, Dr. C. C. Nesselrode, Dr. L. B. Spake, Dr. C. B. Francisco, Dr. John A. Billingsley, all of Kansas City and Dr. F. L. Loveland of Topeka. Scientific exhibits were shown by the following Kansas members: "The Value of Scout Film of the Abdomen" by Dr. Lewis G. Allen; "Viscero-Urologic Complexes" by Dr. O. W. Davidson; "Pathological Specimens-Cancer of the Colon" by Dr. Harry W. King; "Pointers in the Diagnosis and Treatment of Diabetes and Its Complications" by Dr. E. S. Miller; "Blood and Urine Bismuth Values in Routine Antisyphilitic Therapy" by Dr. Ralph H. Major and Dr. Mahlon Delp; "Acute Rheumatic Fever and Its Complications" by Dr. Don Carlos Peete; and "Pathology of the Kidney" by Dean H. R. Wahl and Dr. George A. Walker. Dr. Afred O'Donnell of Ellsworth assisted at the University of Kansas Alumni meeting. Dr. Loveland spoke at an evening meeting on medical plans for care of indigents.

Dr. J. E. Andes, director of the health department of the Sunflower Ordnance Plant who lives in Lawrence,

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has accepted a position as director of student health at the University of West Virginia at Morgantown. Before coming to Lawrence, Dr. Andes was the director of the health department of the University of Arizona, at Tuscon.

Dr. K. M. Rottluff of Bonner Springs has recently been appointed as a member of the health department of Kansas City. The territory for the department includes not only Kansas City but Bonner Springs and the rural sections of Wyandotte County.

Dr. J. R. Rupp, formerly located in Lawrence, and previously to that in Detroit, Michigan, has moved to Liberal.

Dr. M. W. Woodhull of Coffeyville is now with the hospital of the Kansas Ordnance Plant in Parsons.

Dr. H. H. Loewen of Wichita recently completed a post graduate course at the Cook County Hospital in Chicago, Illinois.

COUNTY SOCIETIES

Due to the death of Dr. O. L. Cox of Iola, Dr. Cora Crews of Iola was recently elected as Secretary of Allen County Medical Society to fill the unexpired term of office.

The Bourbon County Medical Society held a meeting in Fort Scott on September 25. Dr. Fred Mayes, director of the division of maternal and child health of the Kansas State Board of Health spoke on the "Maternal and Child Care Plan for Service Men."

The Central Kansas Medical Society held its quarterly meeting in Ellsworth on September 30. Medical officers from Camp Phillips were the guest speakers.

The Clay County Medical Society held a meeting at Clay Center on September 1, at which Dr. T. C. Kimble of Miltonvale gave a demonstration of the "Kenny Treatment for Infantile Paralysis".

Major John Erickson of Strother Field in Winfield, was the guest speaker at a meeting of the Cowley County Medical Society which was held at Strother Field on September 16. A tour of inspection of the hospital was made following the meeting.

The Lyon County Medical Society held a meeting in Emporia on September 7. Dr. C. E. Virden of Kansas City, Missouri spoke on "Consideration of the Methods and Value of Roentgenological Examination of the Gastro-intestinal Tract". At a previous meeting of the group Dr. Fred Mayes of the Kansas State Board of Health discussed the "Kenny Treatment for Poliomyelitis."

The Marion County Medical Society held a meeting in Marion on September 8 to which the public was invited to see a film entitled "The Ominous Arms Case" a picture on water polution.

The Saline County Medical Society and the Kansas Crippled Children's Commission conducted a crippled children's clinic in Salina on September 24. Dr. Charles Rombold of Wichita and Dr. Frank Dickson of Kansas City, Missouri assisted the local physicians in the examinations.

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Resident Medical Director

The Sedgwick County Medical Society held its seventeenth annual golf and skeet shoot in Wichita on September 17. Due to lack of equipment the skeet shoot was cancelled. Dr. J. S. Shaw of Wichita won the golf tournament and was awarded the prize of a desk set and two lifetime Parker pens. A program and dinner followed the tournament.

The Wyandotte County Medical Society held a joint meeting with the Wyandotte County Bar Association in Kansas City on October 11 at the Chamber of Commerce rooms. Mr. William L. VanDevanter, formerly of the United States District Attorney's office spoke on "The Lawyer and the Doctor-a-Critical Analysis". Mr. Thomas H. Finigan of Kansas City and Dr. D. N. Medearis of Kansas City, presidents of the two organizations presided and Dr. C. C. Nesselrode of Kansas City introduced the speakers. At the September 21 meeting of the organization Dr. Hughes W. Day of Kansas City spoke on "Botulism" and Dr. E. O. King of Kansas City discussed "Certain Problems in Aviation Medicine".

DEATH NOTICES

Dr. Omar L. Cox, 76 years of age died of carcinoma of the colon on August 22 at his home in Iola. Dr. Cox was born in Seward, Nebraska in 1894. He was a Captain in World War I and a member of the Allen County Medical Society in which he had held several offices. At the time of his death he was a member of the Kansas State Board of Medical Registration and Examination.

Dr. William Emmett Ham, 85 years of age, died on July 31 of chronic myocarditis and apoplexy at his home in Beattie. He was born in Oxford, Missouri on June 28, 1858 and was graduated from the Rush Medical College of Chicago in 1882 coming to Beattie in 1883. He was an honorary member of the Marshall County Medical Society.

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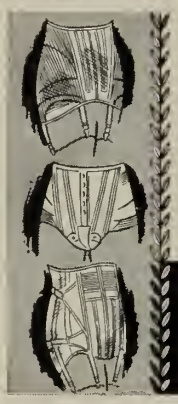
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From tests published in Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245 Laryngoscope, 1935, XLV, No. 2, 149-154

KANSAS MEDICAL ASSISTANTS SOCIETY

The Lyon County Medical Assistants Society held a meeting on September 14 in Emporia. Guests were Mrs. Clyde Wilson and Miss Mary Ann Hannum, laboratory technician. Mrs. Wilson gave two book reviews. The next meeting will be held on October 5.

The Shawnee County Medical Assistants Society held a meeting on September 3 at the Pennant, in Topeka. Miss Janet Hansen, Red Cross Recreational Director now stationed at Winter General Hospital discussed the subject of "Recreation for the Soldiers." The next meeting of the group will be held on October 11.

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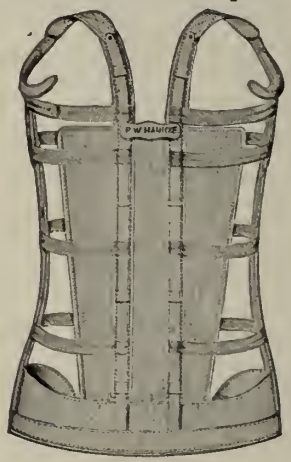
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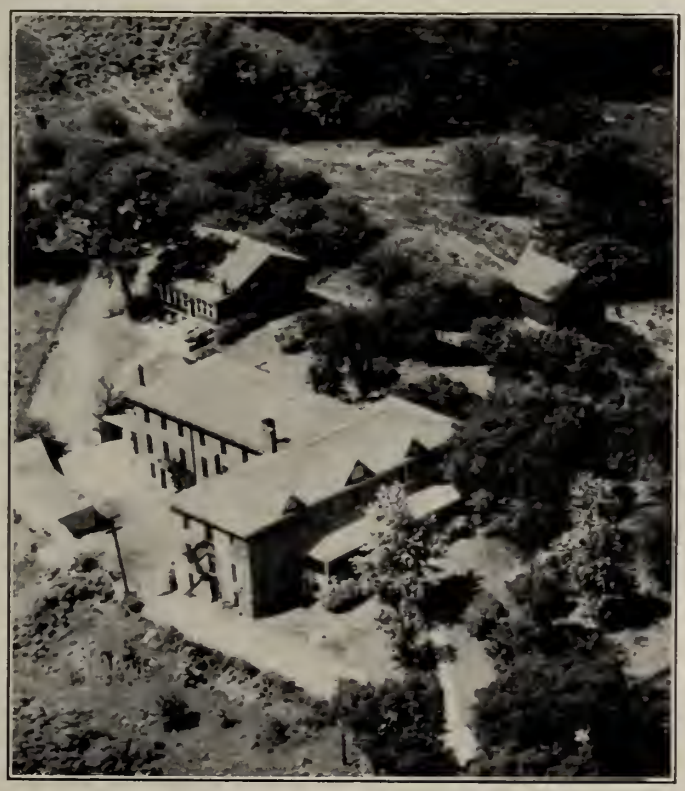
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PRESIDENT'S MESSAGE

The fall board meeting of the Auxiliary to the Kansas Medical Society met in Wichita the twenty-ninth and thirtieth of September with the Wichita members of the board acting as hostesses. In spite of transportation difficulties we had quite a large attendance. It was an inspiration to your president to have so many feel the importance of our Auxiliary that they endured the many inconveniences to get to the board meeting. It is a splendid thing to get together for the exchange of ideas and constructive planning.

The war has given the Auxiliary new opportunities and we must take advantage of these opportunities to help our Auxiliary and to further the aims of the medical profession. If any county president doesn't know just what to do in these times and is a little discouraged, please write to Mrs. Leo Schaefer of Salina to ask her what the Salina County Auxiliary is doing, it will give you new encouragement. Maybe you have a project in your neighborhood your members would like to undertake, be sure to have some plan and try to carry it through. An Auxiliary has to be working to keep alive. In our outlines from National, in program, public relations and war participation there is so much suggested that surely every Auxiliary will find it difficult not to select many of the ideas proposed. The Hygeia chairman will soon be sending out material about the magazine subscriptions. No other magazine can compare with it in its field. We urge people to read it to be correctly informed.

From the National office we are told that post-war planning is now being undertaken and the National resource board has begun to make plans, many of which will affect the practice of medicine. It behooves doctor's wives to interest themselves in the legislative matters now under discussion by the board. Each Auxiliary member should be alert to the changes taking place and assume her responsibility in matters that will affect her husband's profession.

Let us not get so busy with our war work that we neglect our children. The youth of the Nation are those who will carry on what we build today. If we desire this country to be the best place in all the world in which to live we must instill in our children honesty, responsibility and religeous faith.

Sincerely,
Mrs. E. E. Tippin

AUXILIARY NEWS

The Women's Auxiliary to the Wyandotte County Medical Society held its first dessert luncheon at the Council of Clubs recently. Mrs. W. I. Caldwell reviewed "The Exchange" a one act play by Althea Thurston. Fifteen new members have affiliated with the Wyandotte Auxiliary this year.

The Auxiliary to the Shawnee County Medical Society held a meeting at the home of Mrs. E. H. Decker on October 11. Mrs. W. J. Walker and Mrs. L. A. Curry were the assisting hostesses. Lt. Julia Cain, assistant recruiting officer of the "W. A. C.s" in Topeka spoke, Sgt. Margaret Butler, of the Topeka Army Air Base sang a "W. A. C." song accompanied by Mrs. J. T. Casto and Lt. Maude Myers, chief nurse of the Topeka Army Air Base was also a guest speaker.

At a recent meeting of the executive board of the Women's Auxiliary to the Sedgwick County Medical Society Mrs. James Hibbard of Wichita was chosen as the new president to succeed Mrs. W. P. Callahan and Mrs. George Cowles of Wichita to succeed Mrs. L. E. Knapp as the new vice-president. The society has decided to hold only three meetings the coming year the first to be held on October 11 at Droll's tearoom.

SECRETARIES TAKE NOTE

A request has come to the Journal office from Mrs. E. R. Millis, 1517 Minnesota Ave., Kansas City, Kansas asking that all Auxiliary material to be published in the Journal of the Kansas Medical Society be sent to her not later than the first of each month. Mrs. Millis also advises us that the Board meeting held recently in Wichita was most inspirational and helpful. "We will go forward under the fine leadership of our capable President, Mrs. E. E. Tippin." she writes.

These are the days of easy procrastination. The weather, our enforced staying at home and duties connected with the war activity all tend to encourage neglect of the more familiar and routine things.

It cannot be said that our officers and chairmen are being tempted by the lazy wiles of midsummer. Your President's mail is piled high with letters from workers who are planning for our busy and critical year to come. All department heads will publish their programs for the year in our year book to be mailed out on September first. It is hoped that the Auxiliaries of the counties will take into consideration the plans and aims of the state chairmen before completing their own county programs for the year. Any of the chairmen are available for conferences with the county officers.

The county presidents are requested to appoint committees to correspond to the committees of the state board. A list of these committees has recently been mailed to county presidents and officers.

Let us all extend a friendly hand to the wives of our men who are in service. We are their only bond with things medical.—Auxiliary Presidents Message—Journal Medical Society of New Jersey.

What "Zero" Is—When Gabriel Fahrenheit invented the first mercury thermometer in Danzig in 1709, he established his zero degree at the lowest point to which the quicksilver sank during the winter of that year in his city, a standard that has never been changed.—Collier's Weekly.

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Volume XLIV NOVEMBER, 1943 Number 11

FUNDAMENTALS OF PSYCHIATRY XII

PSYCHIATRIC TREATMENT

William C. Menninger, M.D.

Topeka, Kansas

For the practitioner of medicine, the treatment of any disease is the most important practical problem concerning it. Although he is none the less interested in prophylaxis and pathogenesis, the average practitioner is confronted daily with the problem of alleviation and attempt to cure. The aim of all medicine is to attempt insofar as possible to find specificities in treatment methods. All treatment is based on an understanding of the pathology and how the particular diseased part functions in relation to the total individual in health. Treatment, however, requires much more than an understanding of the pathology. In addition to being a science, treatment is an art; the two are inseparable.

No matter what type of physician, and no matter what type of illness he is treating, his skill and knowledge place him somewhat in the role of the magician. Most patients take medicine, accept operations and follow prescriptions in blind faith. The patient's fear of and respect for the doctor place him in a god-like position and consequently his words have a surcharged value, particularly when he refers to his findings or to his advice. Because the psychological factors enter into every type of illness, every physician must deal (and does for better or for worse) with the psychological component. In some illnesses the psychological contribution is the major portion of the illness; in others, it is the minor portion of the illness, but the wise physician keeps in mind that every patient who comes to him with any kind of a complaint is a person with troubles, and not merely a set of organs which are misfunctioning. Although this presentation is concerned chiefly with the treatment of mental disorders, it is applicable in some degree by every physician to every type of illness.

The treatment of any particular type of illness if given in detail should be presented in connection with the pathology of that illness. There are certain general methods and procedures used in the treatment of psychological illnesses which can be summarized. The treatment of mental disorders has undergone a radical change within the last thirty years. Psychiatry has made great progress in this era, but at the moment we are still far short of a general utilization of the facts now known regarding the causation and the treatment for mental disorders. A comparatively small percentage of the medical public is familiar with these advances, and even within the ranks of psychiatry, tradition and facilities hopelessly handicap the full utilization of treatment possibilities. The average general practitioner's armamentarium does not include an adequate evaluation of the psychological life of his patients. His treatment is often limited to platitudes or commands, to pink pills or colored water. Too many of our psychiatric hospitals are limited because of economic factors, and treatment is essentially custodial. But great strides have been and are being made, both in the treatment of mental disorders and in the recognition of the psychological factors in physical illnesses and the proper management of these factors.

TYPES OF TREATMENT

Psychotherapy: Psychotherapy is the most used treatment method in medicine, sometimes knowingly, perhaps more often unknowingly. Every physician in his contact with every patient administers psychotherapy, sometimes with intention and precision, sometimes without intention and with unfortunate results. We might define psychotherapy as any method of treatment which is utilized to influence or direct the psychological control and effort into constructive and beneficial paths. Sometimes the physician may do this by words; sometimes by his unexpressed but evident attitude; sometimes by his procedures. In short, his own attitudes towards the patient and the patient's problem are of major importance in the results that he obtains. One can hardly prescribe attitudes which the physician should adopt, yet in psychiatry certain attitudes have been found to be most generally applicable.

In the first place, the physician needs to be helpful, rather than to appear to be prying into the pa-

tient's life, particularly when he wants to interrogate about points which to the patient seem irrelevant. He needs to establish a feeling of confidence and not one of awe or of importance. He should avoid a hypercritical, moralistic or hostile attitude, but should view all phases of the patient's existence with the same objective scrutiny—his gastro-intestinal life, his love life, his economic problems, and his family history. The physician needs to avoid a condescending attitude in which he minimizes the patient's complaints or admonishes him with platitudes.

For better or for worse, taking the history and the procedure of the examination itself may be extremely important forms of psychotherapy. The patient's avoidance of some subject, his sensitivity about others should be cues to the physician in conducting his examination. The patient's response to the physical examination, particularly of the breasts, of the genito-urinary system, of the rectum, may often be a significant diagnostic aid. But even more important is the fact that the physician's approach to these sensitive areas may be in one instance alarming and in another instance reassuring to the patient. Particularly important may be the examination of the heart and of the blood pressure, and the physician's unguarded statements or trivial comments may greatly alarm the patient.

Various types of semi-formal or even the formal forms of psychotherapy are utilized in the treatment of mental disorders, and many of them have a very wide application to the treatment of general illnesses. The first and the one perhaps most widely used is some form of "suggestion," sometimes with and sometimes without persuasion. This may be a casual suggestion given to the patient verbally, about himself, about his illness, or something he should do about it. Most often these suggestions are directed to the conscious awareness of the patient. Psychiatrists are familiar with the fact that many times such suggestions register in the unconscious of the patient; this is most vividly shown in the very specialized form of suggestive psychotherapy known as hypnosis. In some instances the suggestions are given with firmness, sometimes as commands, sometimes as solicitous inquiries, sometimes as being merely advisory with the idea that the patient himself will pass on the suggestion.

A second common form of the suggestive type of psychotherapy is the use of placeboes. Certainly it is unscientific and unwise to fool a patient or to trick him, but on the other hand there are many instances where the administration of pink pills or colored water with no statement as to their nature, but with the implication that they will be helpful, is quite justified. Sometimes operations fall into this class of being placeboes; whether they may ever be justified on this basis is a matter which can be decided only in the individual case. Certainly many times they are not, and yet every surgeon is familiar with the type of patient who comes to him pleading for an operation even though he may be entirely unable to find a physical or chemical basis which would justify it. Physiotherapy probably exerts its greatest beneficial effect through its placebo-like action of reassurance, of physical contact, of direct manipulative procedures.

A third type of suggestive psychotherapy is that of establishing a regime of living for the patient. In many instances there is little doubt that if the physician will carefully and painstakingly outline a plan of living many patients will adhere to it and profit from it. It was essentially this plan developed by Weir Mitchell in Philadelphia many years ago which featured a combination of rest and special diet and by which he achieved such remarkable success. In some instances it is desirable to outline the hours of the day, specifying just when the patient should be taking exercise, the type of diet, the amount of rest, the time of arising and going to bed, etc. Many patients can profit from the authoritative admonition of the physician to follow out a certain program of living.

A fourth type of suggestive psychotherapy is concerned with environmental changes. Often it is the physician's responsibility to advise that changes be made in the environment; that the individual change his type of business, the amount of application to his work, make some change in the home situation or recommend a vacation. At most these can be only suggestions, but in many instances they are extremely important ones which it should be the physician's responsibility to convey to the patient and/or his family.

Substitution: The second general type of psychotherapy utilized widely in the treatment of mental disorders and applicable equally to many types of general illness is what is called "substitution." Often one cannot very adequately eliminate or suppress the symptoms either by suggestion or by drugs, sometimes not even by surgery. As a consequence one often finds it desirable to provide substitutions for the patient, the aim of which ideally should be to substitute practical and satisfying outlets for his symptoms. Thus, in psychiatric terms we think of both occupational therapy and recreational therapy as being forms of substitution: they provide outlets to meet the patient's needs; they offer opportunities for him to find new types of satisfaction. The physician's prescription to play golf or to bowl, or his prescription to take in certain forms of social

affairs may often be in order. In a great many instances his mandatory order to take up some form of hobby may be extremely beneficial to the patient.

As another form of substitution psychotherapy, many patients could profit if they were especially requested to take up some form of educational therapy. Specifically this means that the patient should attempt some further intellectual growth, that he should invest some of himself in some kind of study, whether it be typing or French, history or art, music or sports. Closely allied with this in psychiatric practice is bibliotherapy, the prescription of specific types of reading. There is little doubt that medicine in general has hardly touched this field, and yet in psychiatric experience we have learned that in many instances the patient through intelligent guidance can learn a great deal more about himself.

Rarely perhaps does the physician have occasion to use it, but we in medicine should recognize that religion may be a substitution therapy. While we decry what appears to be the fallacious and unscientific approach of certain religious practices, there is little doubt that religion does serve for many people as a substitutive form of interest and activity which fortify against the development of symptoms and many times may supplant them.

Last, but in psychiatric practice the most widely used, is the form of psychotherapy known as "expressive" psychotherapy. It includes many special forms, but perhaps most common is a detailed taking of the history and a discussion with the patient of his history. Sometimes certain physicians are mystified as to why this should be of help, but the fact that the patient gets to tell his story, that he has a sympathetic listener, that he seems to feel that he is understood, often produces remarkable results in the alleviation of his difficulties. Sometimes this may require an hour; sometimes it takes many hours, many weeks, and in psychiatric practice occasionally it may require an hour a day for as long as two or three years. Much of this may be in the form of a catharsis, with the physician listening, occasionally making comments or suggestions or expressing an opinion. The use of hypnosis or of psychoanalysis is indicated in certain types of mental difficulties. These forms of psychotherapy, however, must be restricted to those who have had competent training in the field, and even the fact that an individual is a psychiatrist and limits his practice to this work does not necessarily mean that he is competent to undertake these specialized forms of treatment.

DRUGS

The use of various medications in the treatment of psychological illnesses is a relatively limited field. There are four groups of medications, however, which deserve special comment: sedatives, vitamines, endocrines and anti-luetic drugs. The first of these, sedatives, is a class of drugs used very widely by the general practitioners of medicine and probably used more often in the psychiatric hospital than any other group of drugs. In psychiatric practice sedatives are utilized for two purposes: to combat acute excitement, for which a special form of prolonged narcosis is sometimes used; and to relieve minor anxieties and insomnia. In the latter situation this is usually regarded as a crutch for the patient, a temporary one, and such an understanding should exist between the physician and the patient. Many patients are concerned over the possibility of habit formation in taking drugs but only in the case of a few (narcotics, occasionally with barbiturates, or paraldehyde) is there any likelihood of this. Narcotics are rarely used in the psychiatric institution or in psychiatric practice, since fundamentally they are to relieve pain and in that sense are not a sedative. Each physician develops his own particular preference as to the type of sedative he prescribes. Perhaps the most common error is the abuse of bromide and bromide-containing sedatives which should never be prescribed for more than a short period of time, unless the blood bromide test is frequently made. For mild sedation, small doses of chloral and phenobarbital are most commonly used. For stronger sedation sometimes one barbiturate will work when another one will not, and it is through individual preference that a physician may give sodium amytal, nembutal, sodium allurate, ipral, etc. Occasionally patients respond to any of the barbiturates with excitement and in this case paraldehyde is probably the most practical substitute. This drug is also one of the most practical to use in post-alcoholic intoxication states.

The second general class of drugs finding an increasing utilization in the treatment of various neuropsychiatric disorders is the vitamines. Thiamin has become widely used in neurasthenia syndromes, as well as in various types of disturbances with pathological alterations in the peripheral nerves. For these, however, the general use of a vitamin B-complex is probably best indicated. Pellagra is a multiple-vitamin deficiency, but certain of its symptoms respond particularly quickly to nicotinic acid medication. In many instances of prolonged alcoholic usage the vitamin B-complex is indicated. Paralysis agitans in some instances responds to pyridoxine.

The third group of drugs most commonly used in psychiatric practice includes various forms of endocrine medication. There is much speculation, however as to which of these are effective in what con-

ditions. In some instances the use of female hormones is definitely beneficial in involution states, though there seems to be no uniform agreement as to what results may be expected. Thyroid has been extensively used in schizophrenia but with questionable results. Male hormone treatment has as yet given no very conclusive results in specific types of psychiatric difficulties. Mental pictures associated with various pituitary disorders have in most instances failed to show any change with pituitary medication. Despite our failures to date, however, this field is a rich one for research and investigation.

A fourth group of drugs is the anti-syphilitic medications which are utilized frequently in psychiatric practice. The treatment of paretic neurosyphilis is undoubtedly accomplished best through the use of fever, but this method is always supplemented with the anti-syphilitic drugs.

PHYSIOTHERAPY

In addition to the use of fever in the treatment of paretic neurosyphilis other forms of physiotherapy are widely used in psychiatric practice. As has been indicated above, perhaps in many of these instances the chief beneficial effect is entirely psychological, brought about through the personal interest of, and the personal ministrations by the therapist. Undoubtedly there are also definite beneficial physiological effects. The continuous flow immersion tub is widely used for sedative purposes. Other sedative measures like the sitz bath and the wet cold sheet pack are frequently employed. The use of various stimulative procedures like the Scotch douche, different types of showers, and tonic massage is widespread. Many of these physiotherapy procedures could be used much more widely in the general hospital than is the practice at the present time.

SHOCK THERAPY

The use of chemical and electrical shock has become a very important form of treatment for various types of disorders in the last five years. Insulin given in sufficient amount to produce hypoglycemia with consequent stupor or even coma and convulsions, is widely used as a treatment for schizophrenia. A so-called "shock" is carried out daily, six days a week, for a period of six to ten weeks. At the same time that the insulin treatment was developed the use of metrazol, a powerful cardiac stimulant, was introduced. The drug is given intravenously and results in a short, generalized convulsion, followed by a brief period of confusion and return to the preconvulsive picture within two or three hours. A series of from six to fifteen injections with a corresponding number of resulting convulsions has in many instances produced very marked improvement in the mental picture. This type of treatment was originally recommended for schizophrenia but it has proven most effective in the affective disorders—the depressions and excitements and involution melancholia. In many places metrazol is used in conjunction with curare, the latter drug being given first to "soften" the convulsion. By the use of curare the hazard of fracture resulting from the convulsion has been greatly reduced.

Within the last three years the development of electro-shock has largely supplanted the use of metrazol and even insulin in many instances. A controlled dosage of electricity is passed through the frontal poles which results in a short, generalized convulsion. Curare is often used with electro-shock and this method of treatment has proven to be simpler to administer and better controlled than treatment with metrazol.

SURGERY

Within the last five years a neurosurgical procedure has been developed in which some of the association fibers in the frontal lobe are severed. The operation, called a lobectomy, is performed through a trephined area over the frontal lobe, and has been found to be helpful in a certain percentage of chronic mental illnesses. Because of its experimental nature its use to date has been limited largely to chronic forms of disturbance. Any procedure in which there is an intentional destruction of brain organization should be regarded with considerable conservatism, and as a result the use of this procedure is as yet very limited. Many psychiatrists are quite convinced that it is an illogical and dangerous procedure, although its advocates hold quite an opposite view.

PSYCHIATRIC HOSPITAL THERAPY

Probably the major portion of all the treatment administered by every physician could be classified as psychotherapy. Furthermore, a large percentage of patients seen by the private practitioner of psychiatry do not require hospitalization. On the other hand, according to mental hygiene statisticians, one out of every twenty-two adult persons in the United States will require psychiatric hospitalization at some time during his life. Probably a majority of these people are forced to the psychiatric hospital against their will. Fortunately, the average man is gaining some enlightenment in regard to mental illness, and when this enlightenment reaches a stage so that it removes the unwarranted and irrational stigma placed around this form of illness, more physicians and more laymen will recognize the desirability in many instances of psychiatric hospital treatment.

The advantage of psychiatric hospital treatment lies in the fact that it can provide a simplified life situation, a situation in which the patient has no

responsibility, in which no one is critical of his mood fluctuations, in which his misbehavior can be more adequately handled than in any other situation. The whole environment should be so modified that he may function with more ease than in the complicated situation in which he previously existed. The new environment is adapted to him, rather than expecting him to adapt to the environment. Psychiatric hospital care should afford specific and continuous treatment, specific in that it is directed toward meeting the conflict of the individual, and continuous in that every contract that the patient makes throughout every day should guide him toward the same therapeutic goal.

The psychiatric hospital should provide a neutral emotional environment in which the patient has no justifiable prejudices and the doctors, nurses and therapists are not handicapped by an emotional interest in the patient. In this neutral emotional environment the patient is protected, as often he needs to be, from the love or hate of his family, his relatives or his friends. In general the less contact the patient has with these outside emotional contacts, the more he profits from the hospital environment. Last but not least, hospital care is desirable because the opportunities for a patient to injure himself are greatly minimized in contrast to the home or the general hospital situation, and in many instances, it is essential to protect the patient's own home and his business from the consequences of his mental sickness, i. e., his poor judgment, his emotional excesses, and his distorted behavior.

THE REQUIREMENTS FOR SUCCESSFUL HOSPITAL THERAPY

The first requirement for successful psychiatric hospital care is a trained personnel, the nurses and therapists. It is this group that manages the patient's program of activities and it is the personality of these individuals that is in a large measure the treatment of the hospitalized patient. It is their responsibility to create a friendly and secure environment. The nurse must be a confidential friend of the patient, and a companion in recreational and occupational activities. She must be a diplomat in handling actual difficulties that arise concerning treatment and privileges. She must be the doctor's chief observer of the patient's behavior and at the same time, be capable of charting it intelligently and accurately. These functions are only possible when she has a psychiatric knowledge. She must have a functional and not merely a theoretical understanding of psychodynamics. She must know not only the methods used in the therapeutic management of each type of mental illness, but the reasons for them. It is necessary to teach her the various difficulties she may encounter and their solution and their rationale. She must be taught that the companionship or friendship prescribed for the mental patient can and must be scientifically controlled. She must be taught what to observe in the patient and how to record it. Probably the most important lesson in her training is to become objective and nonemotional, and yet at the same time remain sympathetic, friendly and understanding in her relationship to the patient.

A second requirement for hospital therapy is material equipment which will permit the segregation of patients, both as to the severity and nature of their illness, and the segregation of the sexes. The hospital must be equipped with adequate physiotherapy facilities, which should include at least the opportunity to carry out prolonged immersion baths, cold packs, sitz baths, ultraviolet radiation, and various forms of douches and showers. The hospital must provide recreation facilities, and a staff trained both in physical education and psychiatry who can direct the patient in his exercise, sports, games and social activities. The hospital must provide crafts and occupational activities, and again a corps of therapists who can direct these. Since hospital therapy in a large measure can be considered reeducational, an opportunity should be present in every psychiatric hospital to provide educational activities in the form of a library, music training and appreciation, domestic science and household arts, landscaping and horticulture, art work, typing and stenographic classes, and other special opportunities that will meet the need of each individual.

A third requirement for successful hospital treatment is dependent upon a plan of management and a schedule of activities which is specifically prescribed and carried out to meet both conscious and unconscious needs of the individual patient. This detailed set of instructions should be written out by the physician when the patient is admitted, giving the nurses and therapists not only such information as will be helpful about the case, with regard to the diagnosis and unexpected behavior reactions, but also should make specific suggestions with regard to the management and the activities for the patient. Such orders of necessity must be revised frequently.

Included in this prescription the physician should cover the following points:

1. The Attitudes to be Assumed by the Nurses and Therapists Towards the Patient: Without using a specific instance one may say that in all cases the nurse's attitude should be emotionally neutral. When she shows disgust, or fear or irritation, or impatience, she fails in proportion to the exhibition of her emotions. In all instances of aggressive outbursts from patients, she should be defensive and never offensive,

whether this be in the manner of her approach or in the emergency situation when the patient may actually physically or verbally attack her. She must have a friendly attitude, but a friendship which is controlled, much as one can control water that comes from a spigot. In some instances only a little is necessary to be shown, while in other cases much friendliness is to be desired. This, of necessity, should be prescribed by the physician. Always her attitude must be one of protectiveness, protecting the patient against himself, against disturbing external stimuli, whether these be other patients, events that transpire on the hospital floors, or intrusions from outside the hospital in the form of letters, presents, visitors, relatives. It is most important that she understand the nature of the conflict, and through her constant association with the patient carry out those specifically prescribed attitudes which will minister toward the unconscious needs of the patient.

2. Nursing Procedures: Although the chief function of the psychiatric nurse is to manage her own personality in such a way in its relation to patients that she is "good medicine" in herself, she must also function, however, as the trained assistant to the physician who ministers to the physical needs of the patient, namely those supportive procedures as they are applied to physical health—attention to the physical comfort, the administration of medication and dietary supervision, physical hygiene with regard to elimination, baths, and occasionally the more technical procedures of hypodermic medication, hypodermoclyses, rectal administration of medication or nourishment, etc.

3. Occupational Therapy: Occupational therapy is not to be regarded as a pastime, as an amusement, or as a hospital economy. It should be used as an opportunity for the patient to express himself in a more satisfactory outlet. It should be an opportunity for replacing symptoms. It should meet both conscious and unconscious needs. In general, occupational therapy is the most effective outlet for correcting the mismanaged erotic (constructive) drive through the various opportunities for creation, for building, for repairing, for constructing projects of any sort.

4. Recreational Therapy: Recreational therapy should also be applied in a specific fashion, rather than being merely a matter of amusement or pastime. It is most applicable to meeting unconscious emotional needs for the expression of aggression, hostility, hate. This is possible through the opportunities to dig, to pound, to compete, to win.

5. Physiotherapy: The regular routine of physical therapy should include opportunities of sedative, eliminative, stimulative, and tonic benefits. The physical effects are often very beneficial and in many instances the psychological benefits of such treatment are highly important. Physiotherapy produces a psychological benefit in part because the patient gets the complete and undivided attention of the therapist, and it is beneficial in part because he can see that a physical thing is being done for him. Most individuals are inclined to regard their illness, no matter what sort it may be, as in some way or other physical in origin, and physiotherapy presents an opportunity to indicate to the patient that he is receiving a physical approach to his illness.

6. Educational Therapy: Many patients in a psychiatric institution will avail themselves of the opportunity to increase their cultural or intellectual fund of knowledge, and often with very great benefit to their readjustment process. Many times the patient who has to spend several months in the hospital feels that he is getting nowhere, that he is learning nothing, that he is not improving imself, and in such instances an opportunity to take a course in stenography, or music appreciation or design changes his whole attitude toward the treatment process. For somewhat better adjusted patients music lessons or university extension courses are often a source of much satisfaction to them and furnish an opportunity for not only a socially acceptable but a socially commendable effort.

7. Bibliography: Reading as a method of treatment must still be regarded as a hit and miss procedure from a scientific point of view. Nevertheless, many individuals derive a great deal of benefit from it, often gain reassurance, occasionally gain insight through material they read. This is not necessarily limited to mental hygiene literature, since some forms of fiction, biography and history often prove to be of therapeutic value to patients. Its specific prescription is difficult and uncertain. Many patients, however, get an indirect benefit through the diversion and the relaxation as well as the satisfaction in new information gained in reading.

8. Dietary Therapy: Special diets are often indicated in the psychiatric hospital, particularly those to meet special feeding problems, namely tubefeedings, soft diets, diets rich in vitamins. It is essential that the institution be equipped to provide the special diets necessary in diabetes, nephritis, and other physical illnesses.

9. Drug Therapy: Drug therapy is frequently indicated on a symptomatic basis, such as the treatment of insomnia; on a specific basis, as in the treatment of neurosyphilis; and on an empiric basis, as the use of sodium iodide in arteriosclerotic processes; on a deficiency basis, as vitamin tablets in pellagra; on an endocrine basis, as thyroid in myxedema.

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Military doctors play a decisive role in war between nations and in mankind's peacetime fight against disease. Their triumphs in both kinds of war were reported by Col. Edgar Erskine Hume, of the Army's Medical Field Service School at Carlisle Barracks, in a public lecture at the New York Academy of Medicine.

"Half a million men can turn the tide of a war, even in these days of huge armies," Col. Erskine declared.

The United States, he pointed out, might have had that number of men put out of action in World War I, not by enemy guns but by a single disease if our Army had not been effectively protected against typhoid fever. In the first World War there were only 1,500 cases of typhoid fever instead of half a million as would have been expected on the basis of the numbers affected by this disease in our war with Spain in 1898, before doctors knew how to vaccinate against typhoid fever.

"In all past wars disease has struck down more soldiers than all the combined effects of the enemy's weapons," Col. Hume declared. "The soldier's duty is to fight, not to die, for his country. The Army's medical department has the task of keeping him fit, 'To Conserve Fighting Strength,' to quote the motto of the Medical Field Service School, Carlisle Barracks, Pa."

Recalling that the disastrous ending of Napoleon's Russian campaign was the result of an outbreak of typhus fever, to which the Russians were immune but the French and their allies were not, "Who knows but what something of this kind may not happen in the present war in Russia?" Col. Hume asked.

"Horrible though war is, it has stimulated medical advances," he continued. "Some of the world's great medical discoveries have been made by military surgeons, particularly in connection with field service. Every war has added to the sum of medical knowledge."—Science News Letter.

PEPTIC ULCER, AN ENDOCRINE DISEASE

John A. Crabb, M.D.

Topeka, Kansas

In 1927 a demonstrator for a large pharmaceutical house stated that his company's extract of the parathyroid gland was being used to promote the healing of varicose ulcers. Reasoning that if it would cause healing of an ulcer on the leg, it should cause healing in any other part of the body, I began to use it in all of my cases of peptic ulcer. The results have been prompt and almost universally gratifying, the ulcer usually healing and the gastric distress and pain disappearing within a few weeks.

I have been using this therapy for sixteen years, at first necessarily faltering and uncertain on account of inexperience and the lack of knowledge of the strength and effect of the hormone. During the first few years there were several recurrences coming within twelve to eighteen months after treatment had been discontinued. They would yield to treatment promptly. In later years, I have advised my patients to come in for a small dose of hormone every two or three months and have had very few recurrences.

There are those chronic cases of duodenal ulcer where scar tissue obstructs the pylorus in which operation is the only solution and is imperative. In other cases a dense ring of scar tissue may prevent an adequate blood supply to the ulcer and thereby retard or prevent healing, but acute and subacute and most chronic cases respond to parathyroid substitutional therapy and heal promptly.

My usual method of treatment with variations suitable to the individual case is as follows: Give one cc of parathyroid extract every third day for three doses, then ten minims every five to seven days for from six to twelve doses as seems necessary according to the results obtained.

I also use a palliative, such as a bismuth and paregoric mixture or an alkaline powder to be taken twenty or thirty minutes before the expected pain, for the purpose of neutralizing the hydrochloric acid and to coat over and temporarily protect the ulcer from the eroding gastric juice. If it is a gastric ulcer, the pain will usually come on before a meal Some simple food, milk or most any light food which will absorb the gastric juice and keep it from the ulcer, will give almost immediate relief. In such cases, a palliative mixture or powder is given twenty or thirty minutes before meals and the pain is usually prevented.

In duodenal ulcers, the pain usually occurs one and one-half to three hours after meals at the time the food is passing out of the stomach. The time will vary with different individuals but it is usually very regular in a given case, and each patient soon can determine rather accurately the time that his distress will begin. In these cases, the palliative is to be given one and one-half hours after meals or thirty minutes before the expected pain. The palliative may be repeated in ten to twenty minute intervals for a few doses if the pain is not relieved.

It is not advisable to give alkalines immediately after meals at any time. They render pepsin inert and interfere or prevent the proper digestion of proteins. The diet is, of course, sharply restricted in peptic ulcers, but even then it does not seem rational to alkalinize the food immediately after its ingestion. The stomach can be very properly and very thoroughly alkalinized before food is taken, as suggested above.

The diet is restricted to liquids or nourishing non-irritating soft foods for a few days, then it is gradually increased in variety and quantity. Milk and cream are used but the diet is not limited solely to them. Food is given for nourishment and not with the object of causing the ulcer to heal, except as it combines with the gastric juices and temporarily prevents the digestion of the partially devitalised walls of the ulcer.

Some of the foods allowed are milk, cream, cereals, milk toast, meat juices, soft eggs, custards and many other foods which the resourceful doctor may select. There are such differences in the conditions and symptoms of cases that the doctor must use his own judgment in the management of each individual case. No hard and fast rule can be set down covering all cases.

Based on experience in the use of parathyroid hormone in the treatment of peptic ulcer in a large number of cases continuously during the last sixteen years, it is my humble opinion and firm conviction that peptic ulcer is an endocrine disease, and is caused and fails to heal because of a lack in the system of the parathyroid hormone.

The treatment is simply replacement therapy on the same principle that liver hormone is used in pernicious anemia, or thyroid hormone in cretinism or myxedema. It is well known that in these conditions the hormone must be replaced at intervals in order to maintain their normal balance and function, or the condition will recur. Peptic ulcers also recur but this has already been covered above.

It seems to me that the treatment which has been so widely accepted for forty years and is still being

(Continued on Page 373)

President's Page

To the members of the Kansas Medical Society:

During the past few months, I have had a happy experience of just happening in on a couple of county medical society meetings and in each instance, the program was prepared and put on by local talent. In each instance, the material presented was excellent and showed an effort on the part of the physician to prepare his report in a scientific manner. It was not just given on the spur of the moment.

The thought has occurred to me that too many of our county societies have suspended meeting during the duration, because of the times and the difficulty encountered in obtaining out-of-town speakers. One of the best societies in the state has only six members, who meet regularly, have good case and paper presentations at every meeting. Then the fellows in that society feel much closer to one another for having met and discussed these difficult cases.

If we met for scientific reasons only, the meetings would be justified, but there is much important business before organized medicine today, that should be freely discussed.

In my opinion, the officers of a county society that does not hold regular meetings, are not carrying out their duty. I feel very positively that if your officers will call meetings and ask members to present scientific material, your county society will be a great success.

There is strength in organization, your community respects, to a greater degree, the opinions and efforts of a county medical society more than they do those of an individual physician.

Later, I am going to send to the officers of every county medical society, a questionnaire, asking for information about the number of meetings held during the year, with the type of programs and other questions which will tell your state officers whether we are really doing a job as organized medicine.

Sincerely,

J. L. Lattimore M.D.

President, The Kansas Medical Society

EDITORIAL

THE PRESENT STATE OF THE ARMY'S HEALTH

One of the most significant epidemiological studies of recent years, entitled "The Present State of the Army's Health" by Brigadier General James Stevens Simmons, appeared in the Journal of the American Medical Association of July 31, 1943. The comparative data, carefully compiled over several decades and mathematically manipulated vindicates the Army's policy of maintaining a strong division of Preventive Medicine and a Board of Investigation of Epidemics.

Despite progressive improvement in the care afforded the sick and wounded, in each of our wars infectious diseases have produced more disability and death than have the injuries of battle. In the Mexican War and even as recently as the Spanish-American War, diseases caused seven times as many deaths as did battle. By 1917-1919, the ratio had been reduced from 1.16 to 1.0 with the preponderance still in favor of disease.

During the present mobilization period, despite the characteristic increase in admission rates, the over-all mortality rate from all causes has surprisingly declined, slightly but steadily, since 1936. As pointed out this may be attributed to a number of highly significant reasons: improved treatment of wounds and shock and rapid evacuation of the wounded; good nutritional state of the men in the service; no increase in the incidence of Typhoid-paratyphoid rates despite the unsanitary conditions to which the troops are frequently exposed; the low death rate from respiratory diseases—the maximum death rate of 0.24 per thousand per annum is about one five hundredth of the maximum death rate reached at the peak of the 1918 epidemic of influenza; the relatively unimportant rate of measles, mumps, diptheria, small pox being almost non-existant; the remarkable reduction in the case fatality in Epidemic Meningitis (from thirty-four per cent in 1917-1919 to three to five per cent in 1942-1943) as a result of the use of sulfanilomides; and the gratifying fall in the incidence of the venereal diseases.

In an interesting reference to scarlet fever, Brigadier General Simmons states "It has been the policy to consider that the presence of a rash is only one manifestation of streptoccic pharyngitis. Control efforts are directed therefore toward the isolation of all individuals with streptoccic infections of the upper respiratory tract."

The consistently low rates, particularly in those diseases transmitted through the respiratory tract discharges, during the present war reflect the excellent medical care given the troops. They also indicate the soundness of the Army's policy of prompt and early hospitalization of all acute respiratory and communicable diseases. It is doubtful whether any civilian group will better the Army's case fatality figures in the pneumonias and epidemic meningitis. Similar studies have not been published for the Navy as a whole, however, isolated reports indicate comparable results.

In these days of dislocation, when criticism of medical shortages are heard, it is good to see that the wisdom of the early and seemingly endless demands of the procurement and assignment boards for medical personnel have borne tangible results in decreased suffering and lives saved. As greater numbers of troops reach our far flung battle fronts now girdling the world, the incidence of insect borne diseases, diarrheas and dysenteries will increase.

It is hoped that the excellent health record established by the United States Army will be maintained and improved. Their efforts will be reflected in the health of the troops returning from service to the farms, towns and cities of every state.—L. E. Eckles, M. D.

ANNUAL MEETING 1944?

State medical societies throughout the country are facing the decision of whether to hold or to cancel their 1944 annual meeting. The Kansas Medical Society, by decision of the Council, canceled its 1943 scientific meeting, holding only a short business meeting in Topeka. Word is now being received that several state medical societies have scheduled scientific meetings for 1944 along with the information that the loss of even one annual scientific meeting has caused a great hardship to the profession.

In the past year the Kansas Society has substituted a number of post graduate courses on various subjects which have been held in various parts of the state, in its attempt to repair the damage done by the absence of its regular meeting. It is believed that if the Society does not hold an annual meeting in 1944 the loss to the profession and to the public as a whole will be irreparable. Today, new procedures, new methods, new drugs and new practices are being developed in the science of medicine, even as you read this, and tomorrow the profession, by at-

tending an annual scientific meeting will be able to absorb much that science and war have proven of worth in the laboratories and the battle fields of the world.

Kansas medicine cannot afford to postpone indefinitely its annual scientific session.

RATIONAL RATIONING

"One of the impressions gained by reading the testimony given before a subcommittee of the U.S. Senate Committee on Education and Labor, of which Senator Claude Pepper is chairman, as reported in the J.A.M.A.,* is that the numerical distribution of physicians with respect to population is the important thing in the maintenance of the public health, as far as government is concerned.

"We concede that it is important, but it is not the whole story. The modern physician, both urban and rural, depends for his effectiveness upon hospitals, transport, electric power, and the willingness of the people in the area he serves to accept his services. Whether the question is one of bringing the physician to the people or group of people, or the people to the physician or group of physicians, communications are of primary importance. Living conditions, especially in winter, may be of the utmost significance with respect to the amount of disease occurring in a given area. Bungled rationing with respect to gasoline, tires, fuel oil, or power could materially alter the medical efficiency of physicians in a given area no matter what the numerical physician-to-population ratio might be. Similarly, a fuel oil and power shortage in another area might so suddenly increase the amount and severity of disease, so impair the efficiency of hospital operation that the physicians and hospitals, though numerically correct with respect to medical exponents and hospital beds in relation to population, might be unable to cope with the situation.

"It would seem to us that to date no one has paid particular attention to the vital matter of medical effectiveness, which seems likely to become a larger problem as rationing becomes—as it must—more severe and more inclusive. We urge that it be not overlooked in the present concentration of thought on the matter of mere physician distribution. It is to be kept in mind also that as more and more of the young men go into the armed services, the care of the civilian population will be carried on largely by the group of men forty-five years of age and over. In the age group of sixty-five and over a "bare thirty per cent" are effective for all purposes; in the group of forty-five to fifty-four there are 31,399 physicians; in the group of fifty-five to sixty-five, 30,000 physicians. What could be considered the effectiveness of this group, forty-five to sixty-five, comprising 61,399 medical men? Examination of the men for the armed services showed a rapid increase in the number of physical defects for each decade. What significance has this fact when related to the effectiveness of this forty-five to sixty-five age group?

"There is no doubt that a physical examination of this group (forty-five to sixty-five) would show a rapid decline in energy available for civilian population care with each additional decade above forty-five.

"How will this affect the plans for distribution? Is one doctor per 1,500 of population sufficient regardless of the level of the physician group health in that area? What is the level of the physician group health in any given area? Does any one know? We doubt it.

"These 61,399 physicians must last out the duration; there seems to be little prospect of increasing their number. Will we be as wasteful of our physician stock pile as we were of our rubber? As heedless of conservation until it is too late? There can be no synthetic physicians, remember. Isn't it about time we took stock of the group health of the forty-five to sixty-five age group? Isn't it time now to see to it that every facility, for transport especially, and for maximum effectiveness of operation and practice be assured to this small group upon whom rests the responsibility for the national health? Wise planning can effect much benefit; tinkering with a system of medical practice in the middle of a war could be disastrous.

"This is no time to be content with patch-work. Rational rationing and national planning are called for; let us have them, and let them be practical."—New York State Journal of Medicine.

J.A.M.A. 120: 927 ff. (Nov. 21) 1942.

The heroism of an English medical officer, Lieutenant C. G. Rob, the first British paratroop doctor to win the military cross, is described by the regular London, England, correspondent of The Journal of the Americaan Medical Association in the September 11 issue.

The correspondent says that when the doctor dropped by parachute in Tunisia "he broke his leg. Nevertheless he carried on. When the blood transfusion supplies gave out he took a pint of his own blood for a patient. The citation states that he performed some one hundred and forty operations after being dropped by parachute, in many cases under enemy bombing."

Buy United States War Bonds and Stamps

TUBERCULOSIS CONTROL

DANGER FROM FLUOROSCOPY

A number of articles have been published concerning the dangers connected with fluoroscopy. Recent measurements have shown that these warnings must be taken seriously and that they concern the whole medical profession. The problem is more acute now when the serious film shortage may call for more extensive use of the fluoroscope method, and it seems advisable to call attention to a few pertinent facts.

No fluoroscope unit should be used unless the doctor in charge has convinced himself that the conditions under which it is operated are reasonably safe. A continuous vigilance is necessary, and it is not enough to know that the conditions were satisfactory at one time in the past.

A shock-proofed arrangement should remove electrical dangers but a broken cable or a casual repair may lead to electrical hazards, and many of the old machines have exposed high-voltage leads. Grounding a part of the apparatus may not always serve as protection, and if the ground is applied at the wrong place the danger may be increased. A careful expert inspection is needed and there can be no valid excuse for an accidental electrocution. Such accidents have occurred a number of times.

Roentgen rays from fluoroscopic units have caused innumerable sequelae to both patients and physicians, and serious damages often still result in spite of the knowledge that now is available.

In order to obtain adequate protection, it is first required that the tube be shielded so that no radiation of any consequence escapes in any direction except in the useful beam. This may be checked roughly with a hand fluoroscope or more accurately with a rotengen meter with a sensitivity of 0.01 r or a Geiger-Muller Counter. After this first requirement has been fulfilled several other precautions must be taken.

For any intelligent use of fluoroscopy, it is important to know the amount of roentgen rays reaching the skin of the patient and of the examiner, and that has to be determined by means of measurements. The total dose received depends upon the intensity and the time of exposure. The intensity depends upon a number of factors and varies widely in practice. A reasonable intensity at the skin of the patient nearest to the tube amounts to about twenty r per minute.

A representative of the division of Biophysics, University Hospitals, has recently checked some machines in Minnesota, and has found intensities during routine practice up to 114 r per minute. It is evident that such an intensity is dangerous and must be reduced by proper adjustments. The question is how many of the machines which have never been calibrated are used under similar conditions with an unnecessarily high intensity.

The intensity may be reduced by increasing the distance from the target to the patient. This distance should be at least twenty-eight to thirty cm. It can also be reduced by lowering the current which should not exceed four to five ma. If the fluorescence is not bright enough the voltage may be raised and it is advisable to use rather high voltage, preferably eighty kv. or one hundred kv. if possible with the equipment. With a high voltage a filter helps to lower the intensity considerably and a one mm. aluminum filter should be permanently attached.

With the use of twenty-eight cm. target skin distance, ninety kilovolts and four ma. and one mm. aluminum filter, the intensity can undoubtedly be kept within the safe range, but it is still advisable to have it measured so that the number of roentgens applied per minute will be known.

The time used for an examination should be kept at a minimum. It should be measured and recorded. A foot switch should be used so that the current applied to the tube may be limited to the time of inspection. The use of a timer, which sums up the exposure and shuts off the machine when the dose decided on has been given, is advisable.

Some fluoroscopic examinations require an exposure of five minutes. With an intensity of twenty r at the patient's skin, this means a dose of one hundred roentgens. A dose of seventy-five r is often used for treatments of skin diseases and the title of a publication in The Journal of Radiology, "Roentgen Therapy in Fluoroscopy" is, therefore, no exaggeration.

The rules laid down here for the safety of the patient may seem drastic. They are, however, not difficult to follow after they once have been accepted and certainly patients have the right to expect the physician to take the necessary precautions in order to avoid serious injury from a simple examination. These rules also help to protect the examiner, though any injury to him is due to accumulation of exposure over a long time rather than to a single dose. He must be particularly careful to protect the hands which are inevitably exposed at palpation during the fluoroscopic examination. The use of lead-rubber gloves may help but not unless the gloves are heavy and designed to shield the whole hand can they be relied upon to give complete protection. Light gloves

may give a false sense of security. The examiner must in any case be aware of the danger and take all precautions possible.

The most dangerous procedure and the one which has caused most of the injuries is the setting of fracture under fluoroscopic visualization. This practice must be condemned and the radiologist in charge should enforce the rule that nobody on the staff be permitted to use the apparatus in this manner. The doctor may receive enough exposure from the setting of a single fracture to produce a severe skin reaction. It is, of course, good practice to inspect the position fluoroscopically and that can be done several times without exceeding the permissible total dose.

A number of physicians already have suffered the consequences of too much exposure during fluoroscopy. They have been severely handicapped and some have paid with their lives. The tragedy has been extremely impressive, and it is hoped that others will heed the warnings before it is too late.—Danger from Fluoroscopy, K. Wilhelm Stenstrom, Ph.D., Professor of Biophysics, University of Minnesota, Editorial, Minnesota Medicine, June, 1943.

PEPTIC ULCER, AN ENDOCRINE DISEASE

(Continued from Page 368)

used almost exclusively, is strictly palliative. Since it does not strike at nor remove the cause of peptic ulcer, it is temporary in results and there are frequent recurrences.

Surgery is also palliative although at times imperative as in perforation or pyloric stenosis, but every surgeon knows that there are frequent recurrences after major operations. Surgery does not strike at nor remove the cause of peptic ulcer any more than the removal of a gangrenous foot strikes at the cause or cure of diabetes.

If my conclusions are founded on facts and are indeed true, then patients and doctors may expect that the ulcer patient will receive the same measure of relief that other endocrine patients experience when the indicated hormone is properly used. I am sure that the treatment which I have outlined is basically sound, but it will be improved upon and refined and made more effective by the experience of other doctors as its truth becomes more widely known and more definitely established.

CASE REPORTS

Casae I—P.B., age 67, married, a retired grocer, had history suggestive of duodenal ulcer for many years. On May 11, 1925, the ulcer perforated and was closed by operation. He made a recovery but the ulcer recurred. Pyloric stenosis with obstruction resulted and in 1932 a posterior gastro-enterotomy was done. Again he recovered, but later his distress returned. He had been in bed six weeks, then up one week prior to consulting us on January 6, 1937. He had great pain and distress after eating and frequently vomited undigested food several hours after having ingested it. There was evidence of incomplete pyloric stenosis. Treatment with palliatives, digestants, and parathyroid injections was begun. He made some improvement and was very much more comfortable. On April 10, 1937, we have the note, "Peristaltic waves of stomach from left to right indicate pyloric stenosis. Vomits occasionally." His treatment was varied, but we continued with the parathyroid injections rather persistently and from June to September he was very comfortable and very happy. On September 18, 1938, he had some recurrence of pain and was given an injection on September 19, 1939. He reported that he had been quite comfortable all winter up until a few days ago and is now having some distress but it is negligable compared to one year ago. A note at this time says: "We plan to continue replacement therapy. If the obstruction becomes complete, operative relief may become imperative. He has not vomited for many months." August 21, 1942: We have inquired about this patient several times since the above was written and always receive good reports in reference to his health. We visited him today and found him out taking care of his poultry. He is now 71 years of age and has a good healthful color, and is well nourished and vigorous. He has had no serious distress in his stomach since discontinuance of parathyroid injections.

Case II—C.H., male, age 61, farmer, gave a history of "stomach trouble" and "indigestion with pain" for many years. On December 1, 1920, we have the note, "duodenal ulcer?" At that time we gave the "Sippy" treatment which was carried out imperfectly and with unsatisfactory results. He was thin, poorly nourished and had annoying gastric distress. On June 2, 1928, his duodenal ulcer perforated. The perforation was closed and drainage instituted. There was peritonitis and his condition was serious. The gall bladder became infected and was drained July 2, 1928. His condition was grave for several weeks. For sometime after having left the hospital he was psychotic. His emaciation was extreme. He gradually recovered and came to a state of fairly good health. He showed symptoms of recurrent ulcer and on November 2, 1929, we gave him the first dose of "parathyrin," which we had begun to use in 1927. At that time he had a series of nine injections of one cc. each. His symptoms of ulcer disappeared. On October 4, 1930, we gave only one injection. Again from December 15, 1931, to January 2, 1932, we gave a series of five injections. Again from June 3 to June 13, 1936, he had four injections. Again from September 18 to October 22, 1937, four injections were given. The symptoms of ulcer disappeared promptly after each series of injections. Note was made of his progress at this time. "He is in good health, well nourished, has a good color, does his farm work and usually suffers no distress except such as is caused by the dense adhesions resulting from his perforation and the subsequent major operation." After the above mentioned treatment he received injections on January 17, 1938; June 18 and July 2, 1938. On August 21, 1942, he reported that he weighs 155 pounds, is in good health, doing his farm work, and eats everything he desires and has no gastric distress. He is now past 67 years of age. October 15, 1943. He is in good health, has no gastric distress, eats everything that he wants and still weighs 155 pounds.

Case III—H.H., male, age 58, city fireman, has had digestive disturbances for several years. He came to us on

April 24, 1935. A tentative diagnosis of duodenal ulcer was made and he was given fifteen minims of parathyroid extract. This was repeated (ten minims) on April 29, then discontinued on account of another pathological condition until October 7, 1935, when a gastro-intestional x-ray showed "A persistent irregularity of the duodenum, so much so that it emptied as soon as it was filled." This was diagnosed as ulcer of the duodenum. We began a more than usually vigorous parathyroid extract treatment, giving ten minims every other day for four doses, then from five to seven days for about one month. His gastric symptoms improved but a mediastinal carcinoma was developing with its attendant chest symptoms. He also developed symptoms of pyloric obstruction. April 28, 1936, a gastro-intestinal x-ray examination was made. I quote an excerpt of the report: "Stomach fills normally and is probably slightly dialated. No definite filling defect in stomach or duodenal cap. Pylorus appeared slightly narrowed. At leasr half the meal in the stomach in six hours." On June 3, 1936, a pyloroplasty was done. Stenosis and the scar of a healed ulcer was found. The patient died of a mediastinal carcinoma on June 29, 1936.

MEN IN SERVICE

"I just read the October issue and I think it looks swell. Your new section on service members is an interesting idea. I may be in Kansas during November and if so I shall look forward to seeing you all," Major Clarence G. Munns. We hope Major Munns will forgive us for using a part of his letter. He is at the present time in Washington, D. C., office address 4C168 Pentagon Building.

Lt. Col. William C. Menninger of Topeka has been assigned to make a tour of Canada in company with the psychiatric chiefs of the British and Canadian armies. Lt. Col. Menninger is starioned at Atlanta, Georgia, where he is a neuro-psychiatric consultant for Fourth Service Command of the United States Army.

Major Orville R. Clark of Topeka, now in North Africa, writes: "Howard Snyder was here at the same time—just visiting. He is not with the hospital unit any more, but has a professional services consultant job. He is very well liked, and seems to have done a good job. I enjoyed seeing him. His former unit has done a lot of work, and is very well thought of all around. I would say it is always mentioned as one of the three or four top ranking hospitals. He said there had been no casualties among their officer personnel. They have made a record of which they can be proud."

A v-mail letter arrived recently from Major Hiram P. Jones of Lawrence "Please change the address of the Kansas Medical Journal ro—APO No., New York. Have been transferred to this unir. Incidentally Capt. Raymond Leiker of Great Bend is with an Evacuation Hospital in North Africa, Sicily or somewhere and is doing a swell job. Thanks in advance as I enjoy the Journal and am always glad to see it."

Capt. Lewis L. Robbins of Topeka is director of the Mental Hygiene Unit at Drew Field, Florida.

Dr. Marion Trueheart was kind enough to send us a letter from Capt. Leon W. Zimmerman of Liberal. "Somewhere in the South Pacific. I am sorry not to be able to look up your son but as yet I have stumbled into no-one whom I knew at home. It isn't particularly important but maybe I should correct a misconception of yours. I am not a Flight Surgeon although working in an air corps unit. At home I fly under a private pilot's licence and wanted to continue to be in the air part of the time in this work. I am close to it with fighter squadrons all about but actually I don't get close to planes often but have had a few rides. One diversion, aside from routine chores regulating sanitation and general measures of preserving the health of the men, is examining applicants for officers training or for flying cadet school. The war department has a program which allows the enlisted men to be candidates for commissions either as ground officers or as pilots. Of course all cannot go but several have moved up and the plans helps moral as well as providing a high quality experienced man for leadership. Of course all of us are dreaming of coming home. . . .With the accelerated medical training program there will be a lot of us to help there one of these days."

In a recent Men in Service column we listed Lt. Ernest Moser of Holton as being in Africa, the Holton Recorder prints a letter from him in which he has the following to say about Sicily: "I had an interesting trip over from Africa and the country is much different than I had thought for. Every place you go there are children asking for thinks to eat. We have some cantaloupes, watermelons and tomatoes to eat lately and they surely do taste mighty good. There are lots of olive and almond trees. Another improvement over Africa is that we don't have any flies now. It is warm here, too, but not as hot as it was three weeks ago. The lire is the money used here, but it seems very scarce. It is valued at one lire per one cent. We have been busy, so far. The Italians, just as in Africa, seem to be very glad to be captured. Most of the grain has been harvested. They do their threshing by putting the straw in a pile and chasing a horse over it, which knocks the grain out. The grapes look like they would be ripe in about a month." Lt. Moser writes he has seen several doctors from Kansas City, Missouri.

Recent War Department orders list the following: Monte L. Belot, Jr., of Kansas City, promoted from Lieutenant to Captain; Gregg B. Athey of Columbus promoted from Lieutenant ro Captain; Lawrence E. Filkin of Junction City promoted from Captain to Major; and that Dr. Charles V. Minnick of Junction City is ro report for active duty with rhe rank of Captain. All the commissions listed are in the Medical Corps.

Capt. Paul E. Davis of Larned writes: "Kindly change the address to which you are sending me the Journal from Station Hospital Annex, Fort Warren, Wyoming, to the Induction Station, Fort Snelling, Minnesota. I have just received the September, 1943, issue which was forwarded to me."

Mrs. Edward K. Lawrence writes us regarding her husband: "Lt. Col. Edward K. Lawrence (of Hiawatha) has

been in North Africa for more than two months. Likes it very well, but is terribly homesick."

Lt. Ralph D. Ross of Topeka, son of Dr. H. R. Ross of the Kansas State Board of Health, who is a recent graduate of Northwestern University School of Medicine is somewhere in the Southwest Pacific. Lt. Ross is in the United States Navy.

Capt. A. C. Armitage of Hutchinson has been transferred from Jefferson Barraacks, Missouri, to Chanute Field, Rantoul, Illinois.

Capt. H. M. Floersch of Kansas City has recently been transferred from Fort Leonard Wood, Missouri, to Carlisle Barracks, Pennsylvania. He is the son of Dr. M. A. Floersch of Topeka.

Lt. Col. A. J. Rettenmaier of Kansas City has recently been transferred from the McIntire Dispensary at Great Lakes, Illinois to the Naval Reserve Officers Training Corps at the University of Notre Dame in Indiana.

Major T. J. Sims of Kansas City is now stationed in Savannah, Georgia.

Major C. J. Mullen of Kansas City is now stationed at Ft. George Wright in Washington.

Mrs. Clarence A. Gripkey of Kansas City writes advising us: "No doubt the many changes of address are a headache to you, but would appreciate very much, just one more. Lt. C. A. Gripkey, United States Naval Mobile Hospital, care of fleet post office, San Francisco, California, is doctors address and he has requested that I write to you, as he does wish to keep in touch with his native Kansas."

Lt. Comdr. L. E. Eckles of Topeka, whose editorial "The Present State of the Army's Health," appears in this issue of the Journal, has recently been in Topeka on a short furlough. Lt. Comdr. Eckles is now stationed at the Great Lakes Training Station, in Illinois.

Capt. C. G. Davis of Kansas City has been transferred from Brownwood, Texas, to Eldon, Missouri.

Major Robert L. Lee of Kansas City stationed at Athens, Georgia, for a short time is now located at Medford, Oregon.

Two Kansas men were listed as graduating from the School of Aviation Medicine of Randolph Field, Texas, on August 26: Lt. Charles H. Johnson of Kinsley and Lt. Charles R. Magee of Wichita. The course of aviation medical examiner was completed at that time.

Lt. Stephen S. Ellis of Coffeyville has recently been promoted to the rank of Captain. Capt. Ellis is now stationed at O'Reilly General Hospital in Springfield, Missouri.

Capt. Calvin W. Henning of Ottawa is now stationed at the Air Field at Great Bend.

Lt. Henry H. Hyndman of Wichita has been promoted to the rank of Captain. He is now stationed at Fort Riley.

From the section entitled Military News, in the Journal of the Indiana State Medical Association we wish to quote the following written by a Major from that state, who has been on active duty just behind the front lines at Buna, the Major has written home urging civilians to give blood:

" 'From experience gained last fall, the blood of the men and women of American civilians was the means of saving many a son or husband of American and Australian women during those terrible days of the campaign. The dried plasma, reliquified by the addition of a fluid, was not only used to restore the lost volume of blood due to hemorrhage from gunshot wounds, but it was also used to restore strength to the half-starved, dehydrated men who had been living and fighting in the jungle under the most terrible conditions.

"If I had the say, I would state that the most outstanding achievement of the Army doctors during this war so far, has been their use of the dried human plasma. It saved many a life that otherwise would have been lost.

"I hope that when the campaign for donation of blood for the Red Cross opens in New Albany, everyone who can will share some of their blood with the boys who are helping to rid the world of the forces of treachery and intolerance.

"If these everyday American civilians had to go through the 'hell of the jungle' just one day there would be no question about indecision as to whether they should give one lone pint of their blood. Who knows—it may have been a son or brother of their own, in any case it's someone's son or brother!

"And, in a personal paragraph to Mrs. Edwards, he urged, 'don't hesitate to give your blood—it may have been me, you know, who needed it. Give, someone's life may depend on that one pint of your blood!'."

Lt. W. H. Walker, son of Dr. and Mrs. C. W. Walker of Eskridge, has been promoted to the rank of Captain. Lt. Walker is stationed at San Antonio, Texas.

NEWS NOTES

A. M. A. 1944 ANNUAL MEETING

The annual session of the American Medical Association which will be held on June 12-16, 1944, originally scheduled to be held in St. Louis will be held in Chicago, it has been announced by the Board of Trustees of the Association. The change was made due to lack of accommodations in St. Louis.

The meeting of the House of Delegates will be held at the Palmer House and the Scientific Exhibits will also be installed in that hotel, but the Technical Exhibits will be shown at the Stevens Hotel.

PROCUREMENT AND ASSIGNMENT SURVEY

The records of the Kansas office of Procurement and Assignment Service for Physicians are being checked by a representative of the central office at Washington, D. C.

Miss Virginia Schuler, of the Washington office is one of four young women sent out to make the survey which is national in scope. Miss Schuler's territory comprises the Sixth and Seventh Service Command. The survey was started in September and it is believed will be completed by the first of the year.

The information compiled will show the need of a community for additional physicians and will also locate any over-supply of physicians in a community. These latter will then be placed by the state office on the list as available for military service. The survey will bring the central office in closer contact with the field offices. All records are being reviewed and a check is being made to see that central office records and state records agree on all classification and information. A reporting system is being established in order that status, change of location and the availability of all physicians as well as other information can be reported to the central office in the shortest possible time.

Miss Schuler has this to say: "All state medical societies are cooperating with the central office 100 per cent. The Kansas records are in good shape."

HOSPITAL TRAIN

Announcement has been received in the office that the medical profession, the nursing and hospital personnel are invited to inspect the new Third Hospital Train on route to Desert Training Center in Banning, California, which will be in Kansas City, Missouri, on November 30. The train will be found east of the Union Station at Twentieth and McGee Streets. The best hours for physicians, hospital personnel and nursing profession to inspect the train is from 10:00 a.m. to 12:00. The public are permitted to inspect the train from 1:00 to 9:00 p.m.

The ten car train is of steel, fully equipped for field use and the first of its type to be built. The individual cars are each forty feet long of an olive drab color. There are several ward cars, a utility car, kitchen car and cars for officers and enlisted personnel. There will be thirty-three enlisted men, seven officers and several members of the Army Nurses Corps for each such train that is built.

It is hoped that as many of the profession as can will inspect the train while it is in the Kansas City territory.

MEETING

The Menninger Foundation in Topeka held a meeting on November 12 to which members of the profession and those interested in psychiatric problems were invited to hear the guest speaker, Hon. Walter Symington Maclay of London, England. Dr. Maclay has been in Topeka to inspect the Menninger Clinic and Hospital, the Southard School and Winter General Hospital. He is the medical superintendent of the Mill Hill General Hospital in London for the treatment of neuroses in soldiers. Profiting from the experiences of the World War I, treatment in this war has been directed toward social rehabilitation as well as toward the individual neurotic problems. The Mill Hill Hospital is one of the special neurosis centres established in England in the early part of the war.

Under the auspices of the British government and the American Psychiatric Association, Dr. Maclay is visiting universities, medical schools and military hospitals all over the United States. His three talks in Topeka were on the treatment of psychiatric casualties and moving pictures were used to illustrate the prevailing methods. Dr. Maclay stated in Topeka that many of the principles he introduced into his hospital practice had been modeled after the suggestions made by Dr. William Menninger (now a Lieutenant-Colonel in the Medical Corps) in an article in Hospital Management some years ago describing the work done at the Menninger Sanitarium.

SECRETARIES AND EDITORS MEETING

The annual conference of secretaries and editors of constituent state medical associations which was held in Chicago on November 19-20 included the following speakers on its program: James E. Paullin, President of the American Medical Association; George F. Lull, Deputy Surgeon General of the United States Army; Victor Johnson, Secretary of the Council on Medical Education and Hospitals of the A. M. A.; Herman L. Kretschmer, President-Eelect of the A. M. A.; Walter F. Donaldson, Chairman of the War Participation Committee of the A. M. A.; Louis H. Bauer, Chairman of the Council on Medical Service and Public Relations of the A. M. A.; Wingate M. Johnson, editor of the North Carolina Medical Journal; Austin E. Smith, Secretary of the Council on Pharmacy and Chemistry of the A. M. A.; J. W. Holloway, Jr., Director of the Bureau of Legal Medicine and Legislation of the A. M. A.; and L. Fernald Foster, Secretary of the Michigan State Medical Society.

The following problems relating to state societies and medical publications were discussed: Problems and duties of military surgeons; hospital training of medical graduates; co-operative relationship of Procurement and Assignment Service and state medical associations; the War Participation Committee of the A. M. A.; the work of the council on Medical Service and Public Relations; the council on Pharmacy and Chemistry; the Co-operative Medical Advertising Bureau; medical legislature in Congress; and obstetrical and pediatric care of wives and children of service men.

Dr. W. M. Mills of Topeka, editor of the Journal of the Kansas Medical Society, Mr. Robert Brooks, executive secretary, and Dr. F. R. Croson of Clay Center, secretary of the Society attended the meeting.

LECTURE

Announcement has been received in the office that the eighth of the annual Arthur E. Hertzler Lectureship series will be held at the University of Kansas Hospitals on December 1 at 8:00 p. m. Dr. Evarts A. Graham, professor of surgery at Washington University and surgeon-in-chief of the Barnes Hospital in St. Louis, Missouri, will be the speaker. Dr. Graham's subject is "The Problem of Bronchiogenic Carcinoma."

The Alpha Upsilon Chapter of Phi Beta Pi are the sponsors of the lecture and have extended a cordial inviation to members of the Society to attend.

RESOLUTION PASSED BY NURSES ASSOCIATION

At the annual convention of the Kansas State Nurses' Association held in Emporia on October 27-28 the follow-

ing resolution, which we believe is of interest to the membership, was passed.

"We resolve to try to interest the citizens of our state in the establishment of better facilities for the care and isolation of communicable diseases through arranging isolation units in hospitals already in existence and by building hospitals for this purpose in congested areas. That we encourage a better program of education in our own group in the case of these diseases."

QUESTIONS ON MATERNAL AND INFANT CARE PLAN

A great many questions have come up regarding the Kansas Emergency Maternity and Infant Care Program which was inaugurated in the state on June 1, 1943, and which to date has had 3,900 applications, with 3,557 approved. In view of this fact some of the questions and their answers have been listed for your information in the following paragraphs.

In regard to the program the most common cause for rejection of applications is due to the fact that the husband of the applicant is in a rank above the four lower pay grades in service and the most common cause for confusion in payment procedure is due to the fact that many applications are not sent in until late in pregnancy after the attending physician has already provided most or all prenatal care and cannot be paid for these funds for care provided before the date of application.

Three congressional appropriations have been made to finance the program, one in March, one in June and one in September, the total amount granted to Kansas was $274,362 and the total federal appropriation for all states and territories was $24,200,000.

Who is eligible to receive the benefits of the program?

Wives and sick infants, under one year of age, of enlisted men including first four grades, regardless of legal residence or financial status. Change in status or rank of the husband after date of application will not affect the eligibility of his dependent for this care.

Proof of eligibility for benefits of program?

Papers showing the physician her husband's name and service serial number must be presented so that the physician can verify the serial number appearing on the application form with the serial number appearing on the official papers.

Must physician accept patients under this program?

Each physician has the right to participate in the program if he so desires. If he does desire to participate he must comply with the rules of the program set down by the State Board of Health in Kansas, and by the Children's Bureau in Washington.

What fees are paid the physicians in maternity cases?

A physician providing complete maternity care, including obstetric operations and routine blood test for syphilis, will receive a fee of $35.00 of which $10.00 is for antepartum care, $25.00 for delivery, and postpartum care, including an examination approximately six weeks after delivery.

What does the infant program include?

This is the care of sick infants under one year of age. It does not provide payment for routine care of well infants, such as routine physical examinations, immunizations, routine dietary supervision, etc.

Are consultant services provided?

Qualified consultants, when called by the attending physician, may be paid a fee not to exceed $10.00 for advice and assistance rendered the attending physician. When a qualified specialist is called by the attending physician to perform major surgery, he may be paid a fee not to exceed $35.00. In order to provide official authorization for the specialist called by the attending physician, it is necessary for the attending physician to present a request to the Kansas State Board of Health for this consultation service either on form M (Maternity) or form M-1 (Infant Care) soon after consultation if the attending physician has not previously requested authorization for consultation.

Does the program provide additional or other care (medical, surgical and hospital service) than maternity and care of sick infant.

No. If other assistance is needed the wife or mother should contact the local Red Cross chapter or address a communication to the Army or Navy Emergency Relief Office, at the nearest military post.

When does payment for service authorized become effective?

On the date the application is signed by the wife or mother, providing the application is received by the Kansas State Board of Health within seven days of date on application.

What fees will be paid for miscarriage?

Same fees as that paid in regular delivery.

Is a fee paid to anesthetists?

A fee is not paid to an anesthetist if the anesthetist is employed by a hospital on a salary, fee or commission basis. If not an employee of the hospital, a fee may be paid to the anesthetist which will be the prevailing anesthetist's fee for ward patients, with a maximum of $7.50 for any one case.

What type of surgery is provided under the emergency maternity and infant care program?

Surgery performed by a consultant which has a direct relationship to the pregnancy or delivery of the patient may be authorized as well as surgery by a consultant for conditions indicating major surgery in a sick infant under one year of age.

Is the attending physician allowed an additional fee for complications occurring during delivery?

No. The flat fee for delivery by the attending physician covers all necessary services.

If a patient does not request authorization for service during the prenatal period but received such service, may the physician rendering the service charge her direct for such service.

Yes. The provisions of the program do not take effect until the date the application for benefits under the program are signed by the patient. Of course, in such instances, no authorization for payment of prenatal fees under the program would be granted.

If a patient has been going to a physician and has paid him for prenatal service received prior to the date the application for prenatal care under the program is signed, can the physician request authorization for prenatal care or complete maternity care; will payment be authorized; will he be required to refund to the patient fees which he collected prior to the time the application was signed?

Prenatal care or complete maternity care will be authorized if the physician provided at least five prenatal visits after the application is signed. He will not be required to refund fees collected from the patient but he can not

make further charges of the patient after the application is signed.

When should the attending physician submit his fee bill and case report for a maternity case?

After he has completed the postpartum examination, approximately six weeks after delivery.

When should the attending physician submit his fee bill and case report for an infant care case?

Immediately after the discharge of the patient or at the end of the three-weeks authorization period if the patient is not discharged prior to that time.

How may the initial authorization for medical care of a sick infant or premature infant for a period of not to exceed three weeks be extended?

An application for extension on form M 7 must be submitted to the Kansas State Board of Health, accompanied by reasons for the request. In the case of premature infants, the weight of the infant at the time the subsequent request is filed should be given.

What services should be described and itemized by the physician?

In a maternity case: Date of each prenatal visit, date of delivery and date of postpartum examination. In a sick infant case: Date and place of each visit.

Can hospital care be provided under this program when the patient or her family desire to pay the physician his fee?

No. The physician in signing the request for authorization for maternity or infant care agree not to receive payment from the patient or her family for services authorized.

What hospital are eligible to participate in the program?

Only those approved by the American College of Surgeons, or approved after inspection by the Kansas State Board of Health.

How shall the hospital know that the applicant actually is eligible?

The hospital will receive an authorization from the Kansas State Board of Health for each case.

If the patient applies directly to the hospital what should the hospital do?

The hospital should direct the patient to the physician of her choice.

How does the hospital know it will receive a patient for care?

In maternity cases the authorization will come to the hospital from the Kansas State Board of Health, usually several months in advance of admission. In infant care cases the authorization also will come from the State Board of Health, but in case of an emergency the hospital may accept the patient on word of the physician that hospital care is urgently neeeded. The physician must so notify the State Board of Health within twenty-four hours after which the Board will send the authorization directly to the hospital.

How much is the hospital paid? By whom? When? How should the billing be handled?

The Children's Bureau has agreed to pay Kansas hospitals, which have provided care in excees of $5.00 at the original blanket fee ($4.50 per patient), on the basis of the following formula: The certified per diem cost of each hospital rate less 15 per cent, (which is designed to bring the rate down to ward cost). Hospitals unable to submit cost statements may participate and be paid at a rate not to exceed $4.25 per patient. Bills are to be submitted by the hospital to the Kansas State Board of Health on a form which will be sent to the hospital by the Kansas Board of Health with the authorization for service. Bills will be paid by the Board of Health as quickly as possible after their receipt.

Does this rate include all hospital services?

Yes, excepting only blood or plasma or unavailable expensive drugs, which may be billed in addition to the per diem rate.

Does the Emergency Maternity and Infant Care Program provide other than ward service?

No.

If the patient wished better accommodations and agrees to pay the difference between ward service and these better accommodations will the bill for ward service be paid?

No. The hospital agrees not ao accept additional payment from the patient or her family for services authorized under the program.

Suppose arrangements have been made with a certain hospital for maternity care and at the time the patient is ready for delivery the hospital has no facilities available?

In that event the patient may be admitted to another hospital on order of the attending physician, who must then notify the Kansas State Board of Health of this change within twenty-four hours, and the Board will then issue an authorization to the hospital in which the patient was delivered, provoding the second hospital is eligible to participate.

How long may the patient be kept in a hospital?

The maximum authorized is for fourteen days but additional authorization for fourteen-day periods will be considered if the attending physician submits applications for extension and reasons as to why additional hospital care is necessary. The Kansas State Board of Health recommends a minimum hospitalization period of ten days in maternity cases. This does not mean that a patient may not be discharged in less than ten days if, in the opinion of the attending physician, she is well enough to leave the hospital.

Is private duty nursing care provided?

When the patient is seriously ill, the attending physician may request private duty nurses who may be authorized for a period not to exceed fourteen days at prevailing rates, for each nurse. Authorization is only provided to registered Kansas nurses, or those elegible for registration.

Under what conditions are ambulance services provided?

Ambulance service is only provided in emergencies and in unusual cases upon the request of the attending physician.

What charges are permitted for ambulance service?

The charge for ambulance service under this program should be the same as those usually made to patients being admitted to wards in hospitals.

Is the firm or company providing the ambulance notified that ambulance service has been authorized?

Yes. Upon the request for an ambulance by the attending physician, the firm or company will be sent authorization and also a form on which the report of ambulance service will be submitted to the Kansas State Board of Health for payment.

How will ambulance service be authorized in case of emergencies?

The physician requesting an ambulance for an emergency must submit to the Director, Division of Maternal and Child Hygiene of the Kansas State Board of Health, and official request for such emergency ambulance service on

the form for special service (Form M-7) within twenty-four hours after such ambulance service is provided.

Any further questions regarding the Kansas Maternal and Infant Care for Service Men will be answered if you write to the Director of Maternal and Child Welfare, Dr. Fred Mayes, the Kansas State Board of Health, Topeka, Kansas.

BLIND PROGRAM

Dr. W. W. Reed, state supervising ophthalmologist for the Kansas State Board of Social Welfare, recently issued the following report pertaining to examination and treatment furnished under the Kansas blind program as of September 30, 1943:

PROGRESS REPORT
Eye Examinations

"Aid to the Blind" Applicants	Sept.	1943	To Date
New—Approved	14	111	2795
Ineligible	7	82	2079
	21	193	4874
Re-Exam.—Approved	2	38	
Ineligible	3	22	
	5	60	583
Treatment Applicants			
New	0	9	
Re-Examinations	1	2	
	1	11	11
Total Eye Examinations Given	27	264	5468
Total New Approvals for "Aid to the Blind"	14	125	

"RESTORATION OF SIGHT"

Recommendations for Treatment	Sept.	1943	To Date
New Cases	8	66	
Re-Examinations	1	21	
	9	87	1306
Cases Under Treatment	126		

Completed Treatment Cases	Sept.	1943			
Little, or no improvement in vision	1	39			
Less: Re-Opened cases	—0	— 7	1	32	295
Sufficient improvement in vision to remove client from "A.B." category	2	43			
Less: Re-Opened cases	—1	— 3	1	40	484
			2	72	779

"PREVENTION OF BLINDNESS"

Recommendations for Treatment	Sept.	1943	To Date
New	3	59	720
Cases Under Treatment	63		
Completed Treatment Cases			
Vision lost in spite of treatment (client comes within definition of blindness)	0	3	12
Vision maintained or improved with treatment (vision better than 20/200)	1	52	
Less: Re-Opened cases	—1	—16	—1 36 476
			—1 39 488

GENERAL PRACTICE CLINICS

Volume I, Number 1 of the new publication "General Practice Clinics" has come to the editorial desk, dated September and October, 1943. The 124 page magazine is published in Washington, D. C., by the Washington Institute of Medicine, 314 Randolph Place, N. E., and the subscription price is $9.00 per year. The first issue covers many subjects on medicine, surgery, obstetrics and gynecology, and otorhinolaryngology. The succeeding numbers will also include articles on dermatology, pediatrics, and urology, and in so far as possible cover all the conditions and problems of medical practice in which the general practitioner is called upon to treat daily.

The new publication will be issued bi-monthly with each issue containing a cross reference subject and author index, and cumulative index included at the completion of each volume.

Abstracts on 124 various subjects are taken from both foreign and American sources. From Kansas Dr. Leroy A. Calkins, Dr. Ralph H. Major, and Dr. Thomas G. Orr of the University of Kansas School of Medicine are listed as members of the editorial board of the new publication.

KANSAS ACCIDENTAL DEATH REPORT

The 1943 edition of the Kansas accidental death report has recently been released by Dr. F. C. Beelman, executive secretary of the Kansas State Board of Health. This is the eleventh year such a report has been compiled in the belief that issuance of accumulated data might point the way to prevention of many accidents in the state.

In 1942, there were 1,360 fatalities recorded, the fewest number since 1939. The past year shows a decrease of sixty-seven from the previous years total of 1,427.

Motor vehicle accidents caused the greatest number of deaths, with 370 listed. However, this was a decrease of 167 as compared to the 1941 report. Occupational deaths increased by forty-seven over the 1941 report. There were 547 home deaths, an increase of thirty over the previous year; and 213 public deaths which was an increase of twenty-three. There were 883 male deaths and 477 female deaths listed during the year.

The booklet gives statistics on cause of death, deaths by months, sex of the individual, age group, type of injury, seasonal hazards and deaths by counties.

Transportation and public utilities were given as the cause for twenty-eight deaths in 1942, twenty-six were due to construction, nine deaths due to mining and quarrying and eight due to manufacturing injuries.

An eleven-year period from 1930 to 1942 listed causes of death from farm accidents as follows: 333 deaths from machinery, 225 deaths due to animals, 121 falls, 104 deaths due to excessive heat, 113 vehicular deaths, seventy-one due to lightning, forty-eight due to puncture, incised wounds or abrasions, forty-five from injuries by falling trees, forty-two accidental burns, fifteen due to excessive cold and fifty-nine various other farm causes. In 1942, there were eighty-eight deaths from farm injuries.

Of the 547 home deaths in the eleven-year period, 321 were due to falls, eighty-six to burns and conflagrations, twenty-three to poison, twenty to firearms, nineteen to absorption of poisonous gas, fourteen to mechanical suffocation, three to excessive heat, and sixty-one to other home accidents. The cause of such accidents were listed as: Slippery floors, weakness and advanced age, sitting down or getting up from chairs, tripping or stumbling, dizzy or overbalanced and other reasons. Eighty-three of these accidents occurred in bed rooms, twenty-nine on the stairs, twenty-one in the living room, nineteen in the kitchen, sixteen in the basement, eleven in the dining room and sixty-three in other places or place of the accident not listed in the report.

Motor vehicle collisions in the past eleven years in Kansas have caused 1,663 deaths. In every year but one since 1932 this has been the outstanding cause of death. Collisions with fixed objects in the past eleven years have caused 638 deaths.

The book lists many safety suggestions for all types of accidents.

KANSAS POPULATION INCREASES

According to a report in the October, 1943, issue of the Kansas Government Journal the population of Kansas for March 1, 1943, was 1,803,201 a gain of 58,752 or .33 of one per cent. The enumeration of inhabitants was certified to the State Board of Agriculture through county assessors.

Twenty-nine counties show increases and seventy-five counties report loss in population for the year.

MEDICAL MOTION PICTURES

Medical motion pictures are available to medical societies, hospitals and other medical groups, through the American Medical Association, the only expense incurred is transportation both ways, unless films are damaged.

Movies may be secured on the following general subjects: Anesthesia, physical therapy, syphilis, and many other general subjects. Requests for films should be sent direct to the Director of Scientific Exhibits, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

CRITICISM OF BLUE CROSS EDITORIAL

The editorial on the Blue Cross plan as operated in Kansas, published in the October issue of the Journal and expressing the views of the board, has brought forth the following critical comment from Dr. Newman C. Nash of Wichita. As it has been the policy of the Journal of the Kansas Medical Society to be as unbiased as possible on all controversial issues pertaining to the profession, we are publishing Dr. Nash's letter in full.

October 20, 1943."

"In opening my October copy of the Journal to the editorial page, I find a story of the 'Blue Cross.' There are many distinguished members of our medical society who are either officers or directors of this organization and perhaps they may not be as enlightened on the aims and ambitions of this organization as they should be. In fact, the very first statement of the editorial is misleading in stating 'has won the approval and backing of the American Hospital Association, the physicians of the country, 2,500 community hospitals, and 12,000,000 subscribers'."

"Perhaps it might be well to refer to the statements made by the Reference Committee of the American Medical Association convention this past summer 'that factual data contained therein concerns the whole future of the practice of medicine. Unless the medical profession as a whole is willing to devote at least the same amount of time and effort in studying the report and correcting the dangers pointed out therein as the Board of Trustees has in compiling it, then we might as well throw in the sponge and consent to lay domination of the practice of medicine.' "

" 'That the Blue Cross plans to give medical service with or without the approval of the medical profession there can be no doubt after reading this report. The fact that the House of Delegates on numerous occasions has declared against the selling of medical service by hospitals has not stopped the practice. National approval or disapproval of any practice is a waste of time unless the state and county organization will see that the dicta of the national body are carried out in the small localities.' "

"In the October issue of Medical Economics, you will find two articles on the Blue Cross in answer to Mac F. Cahal's article in the August issue of the same magazine. The article from Modern Hospital as an editorial contains the following:

" 'The time must come shortly when the more intelligent doctors in the American medical profession will assume their proper leadership. In the meantime, hospitals and Blue Cross plans must go forward serving the public in newer and better ways, serene in the confidence that sooner or later the majority of the medical profession will thank them for a progressive and socially minded program that offers the greatest hope of avoiding federal control of hospital service'."

"From all of the evidence that has been compiled and presented to the American Medical Association there is no doubt regarding the ambitions of the Blue Cross and the American Hospital Association. For those who read their editorials, as far as the medical profession is concerned, 'the handwriting is on the wall.' If the members in our Kansas Medical Society are going to be taken in by this so-called innocuous prepayment plan of hospital service, then it is high time that we familiarize ourselves with the true background of their current and future ambitions. Today we have so many pressure groups trying to direct or control our acctivities that one more plan doesn't seem very important, but it is highly possible that in the not too distant future we physicians are going to find ourselves caught in the dilemma of whether to practice the art of medicine for the government or for the hospitals."

MEMBERS

Dr. John W. Cavanaugh of Topeka, associated with Dr. W. M. Mills for the past six months, is the co-author of an article on "Modern Aids in the Treatment of Appendicitis" which was published in the October issue of the Journal of the Oklahoma Medical Association. Dr. Cavanaugh is leaving Topeka in December to return to Oklahoma City where he has accepted a position as assistant professor of surgery at the University of Oklahoma Medical School.

The article on "Artificial Respiration in Poliomyelitis—the Civil Air Patrol Method" by Dr. Louis K. Zimmer of Lawrence, published in the September issue of the Journal has elicited considerable comment in newspapers in Kansas City, Missouri, Ottawa and Wichita. Brief excerpts from the article were published in the news release.

An article entitled "A Case of Staphylococcic Actinophytosis (Botryomycosis) in Man: The Tenth Reported Human Case" by Charles H. Drake, Ph.D., Mervin T. Sudler, M.D., and R. I. Canuteson, M.D., of Lawrence was published in the October 9 issue of the Journal of the American Medical Association.

Dr. F. C. Beelman, Dr. Fred Mayes, Dr. R. M. Sorensen, Dr. C. H. Kinnaman, and Dr. H. L. Hiebert of Topeka attended the meeting of the American Public Health Association which was held in New York City on October 12-14.



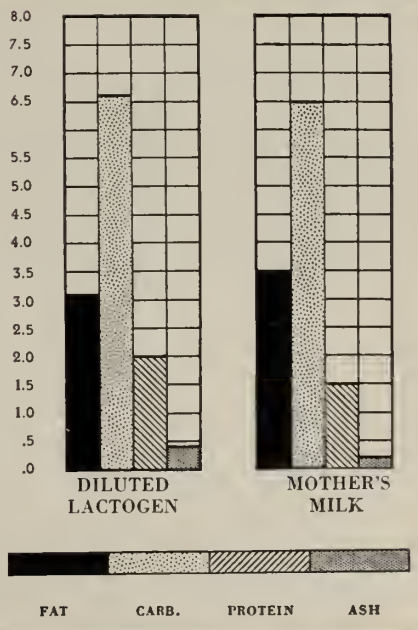


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"My own belief is, as already stated, that the average well baby thrives best on artificial foods in which the relations of the fat, sugar, and protein in the mixture are similar to those in human milk."—John Lovett Morse, A.M., M.D., Clinical Pediatrics, p. 156.

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Recently news has been received from Kansas City that Dr. Geo. M. Gray is greatly improved and able to sit up. Dr. Gray fell on August 7 and broke his hip.

Dr. M. J. Miller of Plainville has accepted a position in the medical clinic of the North American Aviation Bomber Plant in Kansas City. Dr. Miller had practiced in Plainville for thirty years.

DEATHS

Dr. Charles R. Nelson, 65 years of age, died on October 18 at his home in Jamestown. He was graduated from the Southwest School of Medicine and Hospital in 1940 and practiced in Jamestown and in Concordia. He was an honorary member of the Cloud County Medical Society.

Dr. Edward Gates Davis, 77 years of age, died on January 23, 1943, at his home in Kansas City. He was graduated from the College of Physicians and Surgeons of Kansas City in 1898 and was a member of the Wyandotte County Medical Society.

Dr. Orrie Hugh Ball, Sr., 72 years of age, died on November 2 at his home in Dennis. Dr. Ball was graduated from the University Medical College of Kansas City in 1900. He was an honorary member of the Labette County Medical Society. Two sons are in the medical service: Lt. Cmdr. Orrie H. Ball, Jr., and Lt. Wilbur Guy Ball.

Dr. Alexander J. Berger, 59 years of age, died on November 2 at his home in Parsons. He was born on May 9, 1884, at Chilton, Wisconsin, and was graduated from the Milwaukee Medical College in 1906. During World War I he served as a Major in the Army Medical Corps. Before moving to Parsons he lived in Arkansas City. He was a member of the Cowley County Medical Society.

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

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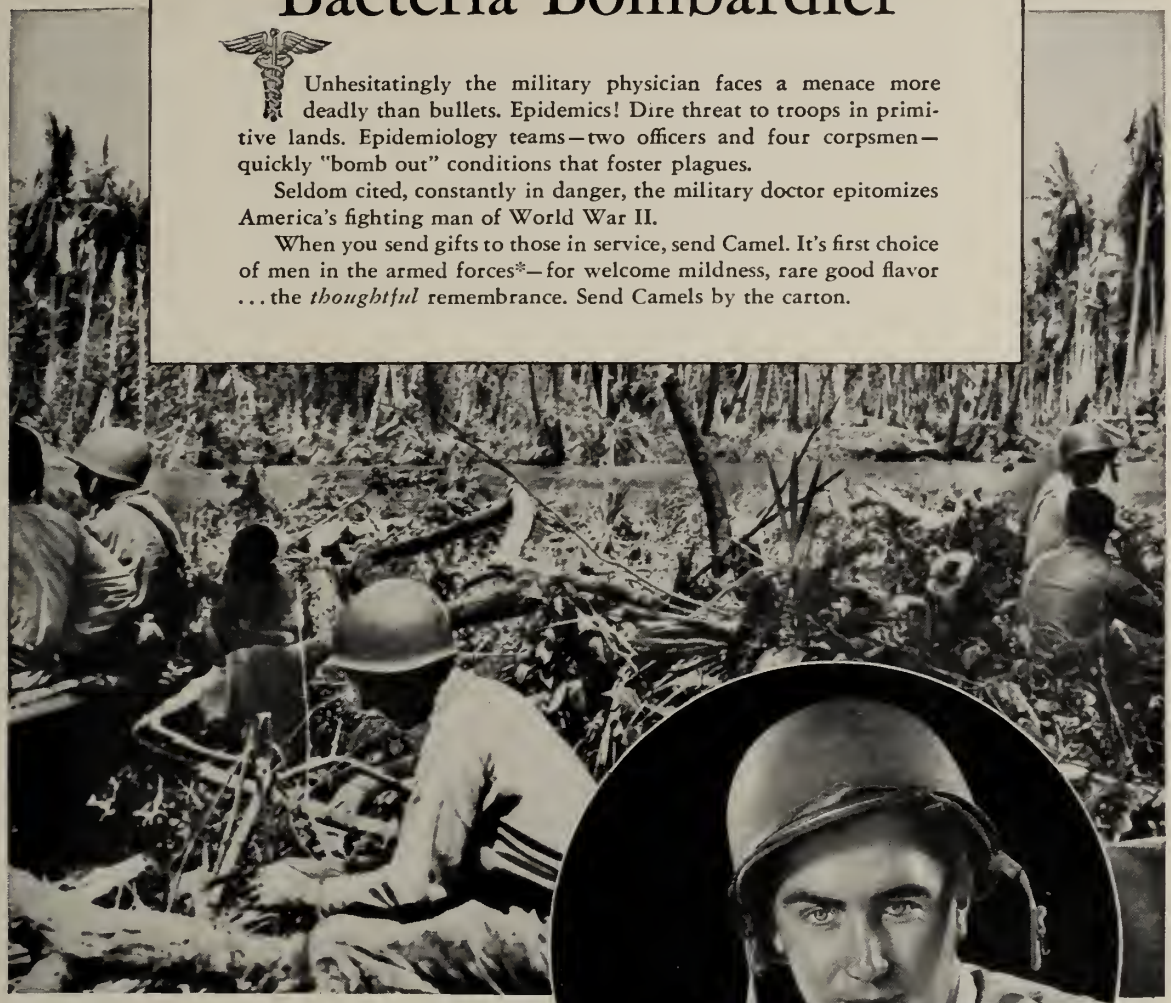
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New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Copies on request. Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York 17, N. Y.

Dr. Luther W. Fowler, 68 years of age, died on October 18 at his home in El Dorado. He was born on August 7, 1875, in Cole County, Missouri, and was graduated from the National University of Arts and Science Medical Department of St. Louis, Missouri, in 1899. He was a member of the Butler-Greenwood County Medical Society.

COUNTY SOCIETIES

The Butler-Greenwood County Medical Society held a meeting at the Allen County Memorial Hospital on October 8. Dr. W. E. Regier of Whitewater showed several scientific movies.

Several county societies have conducted crippled children's clinics in the past month. The Finney County Society held one in Garden City on November 12, the Ford County Society held a clinic in Dodge City on October 22 and the Labette County Society held a clinic on October 15. All clinics are conducted under the direction of the Kansas Crippled Children's Commission with the assistance of Dr. C. B. Francisco of Kansas City and Dr. F. E. Coffey of Hays.

The Rice County Medical Society held a meeting on October 28 at the Trueheart Clinic in Sterling. Dr. Guy Walker of Hutchinson and Dr. John B. Jarrott of Oklahoma City, Oklahoma, were the speakers.

The Sedgwick County Medical Society held a meeting in Wichita on October 5. Lt. Col. Edgar V. Allen of the Seventh Service Command of Omaha, Nebraska, spoke on "The Need for and the Clinical Use of Anticoagulants." Lt. Col. Allen was an Associate Professor of Medicine at the University of Minnesota previous to his entrance into the Army.

Dr. Edward Massie of the department of internal medicine of the Washington University School of Medicine in St. Louis, Missouri, discussed "Recent Advances in Internal Medicine" before the September 27 meeting of the Shawnee County Medical Society in Topeka.

The Wilson County Medical Society met in Neodesha on October 25. The November meeting of the society will be held in Fredonia.

The Wyandotte County Medical Society held a meeting in Kansas City on October 19. Dr. H. L. Hiebert of the Kansas State Board of Health discussed "Photofluorographic Radiography in Tuberculosis" and Or. P. H. Lorhan of Kansas City discusses "Caudal Anesthesia" showing movies on the same subject loaned by courtesy of Eli Lilly Company.

FINDS SPRAINED ANKLE RECOVERY IS HASTENED BY IMMEDIATE USE

Immediate and normal use of a sprained ankle and foot almost irrespective of the type of local treatment definitely hastens recovery, Lieut. Comdr. Paul E. McMaster, U.S.N.R., declares in the July 3 issue of The Journal of the American Medical Association in a report on his observations in more



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MEDICINE—Course to be announced in January.

FRACTURES & TRAUMATIC SURGERY—Courses to be announced in January.

GYNECOLOGY—Two Weeks Intensive course starting February 7th. One Week Personal Course in Vaginal Approach to Pelvic Surgery starting November 1st. Clinical and Diagnostic Courses.

OBSTETRICS — Two Weeks Intensive Course starting February 21st.

ANESTHESIA—One Week Course in Continuous Caudal Anesthesia for Obstetrics.

OPHTHALMOLOGY—Clinical Course.

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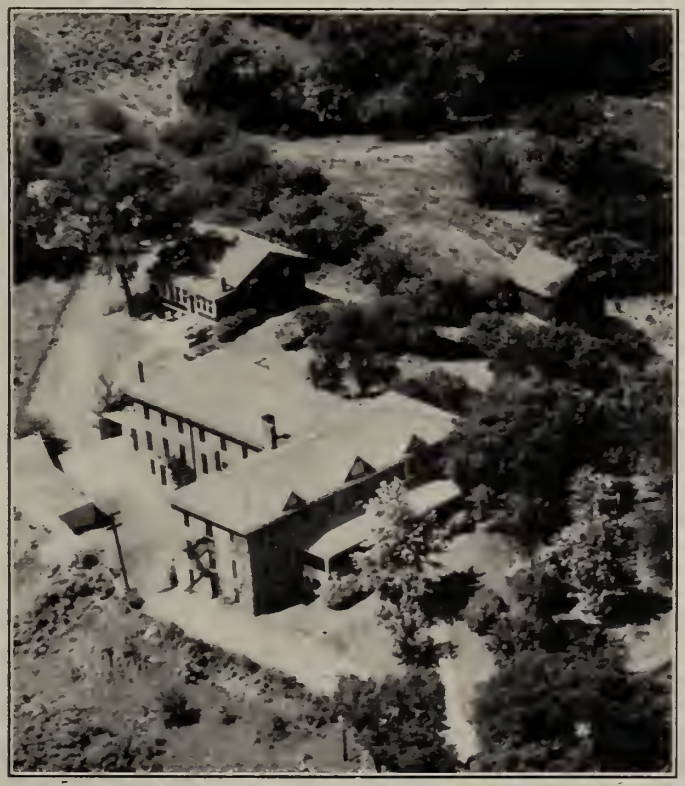
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injection continued immediate use of the part, avoiding only especially strenuous activity as hard running or jumping."

As Dr. McMaster points out, ankle sprains may cause much disability, and often do, in military, industrial and other activities. The patients discussed in his report were men in active military service mostly in the late teens and twentes, and eight women, treated in the Orthopedic Department of the United States Marine Corps Base Dispensary, San Diego, California. All degrees of sprain from minor to severe were seen, but in each case the condition was sufficient to cause the man to seek relief either immediately or within the first day or so.

X-rays of the injured ankles were made almost routinely. No cases of fracture, including sprain fracture, are included in Dr. McMaster's series. Any type of fracture would contraindicate the immediate use of the part involved.

Various types of treatment were used for comparison. Over 200 patients were strapped with adhesive tape, some of whom were sent immediately to duty and the others were instructed to limit weight bearing and protect the ankle either by complete bed rest or by use of crutches or cane. Bed rest without weight bearing for a day or more with initial cold applications and later hot to reduce swelling was tried in twenty-two cases. Twenty-eight patients were given only an elastic bandage support, while eighteen with mild to moderately severe sprains were given no treatment and both latter groups were sent back to duty immediately.

More than 200 patients received local injections of procaine hydrochloride and with but few exceptions were sent to duty immediately.

The technic of injection of an anesthetic to suppress pain in the case of fractures, as used by Dr. McMaster, is not new. It was first reported by R. Leriche in 1928. Dr. McMaster describes the procedure used by him as follows: "The sprained ligaments indicated by tender points are determined by palpation. An antiseptic is then applied to the skin. Two per cent procaine hydrochloride solution . . . is used routinely . . . and the underlying injured ligament is injected. All tender points . . . are injected. A search is then made for tender areas in other ligaments and these are each carefully injected until no tender or painful areas remain either with palpation or ankle and foot motion. . . . Next an elastic bandage is wrapped snugly around the ankle, and the patient is requested to

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walk around the room. If any pain is experienced, further injection is done. The patient is then returned to activity with instruction to use and move the foot and ankle normally, except for running and jumping. Also it is stressed that while sitting as at a desk or table, the foot should be moved and not kept immobile in one position even for short periods. The elastic bandage is to be removed and rewrapped by the patient in one to two hours to prevent possible circulatory constriction. Daily and periodic return for check-up is required in all cases. . . ."

Those inactivated, partially or completely, were often disabled from a few days to two or three weeks.

WOMEN DOCTORS IN THE NAVY

According to a report in the Journal of the A.M.A. the Navy is now granting reserve commissions in the Medical Corps to qualified women physicians in the ranks of lieutenant commander, lieutenant, and lieutenant (junior grade). An original request for 600 women, two hundred to be commissioned in each grade was made. Women, in applying for commissions, must meet the same requirements as men and must be approved by the Procurement and Assignment Service for Physicians in order to prevent depletion of the civilian needs in any community. The age limits for general medical officers are 21-35, and for specialist medical officers 27-50. All applicants must be graduates of accredited medical schools and have at least one year's internship in an approved hospital, duly licensed to practice medicine and be a member of a state or local medical society. In addition, applicants for specialist commission must have had at least three year's recent practical experience in the specialty.

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KANSAS MEDICAL ASSISTANTS SOCIETY

The members of the Cowley Medical Assistants Society were taken on a tour of inspection of the post hospital at Strother Air Field on October 21 in Winfield. Lt. Ryan and Lt. Blaine, nurses at the field conducted the inspection tour and those attending were later taken to the home of Mrs. Josephine McCartney for refreshments.

The Lyon County Medical Assistants Society held a dinner meeting on October 5 at the home of Dr. and Mrs. Frank Foncannon in Emporia.

The Reno County Medical Assistants Society held a meeting in Hutchinson in October to fill the vacancies made by the resignation of both the President and Vice-President. Mrs. Olive Sherman was elected as the new President and Miss Ella Schmidt the new Vice-President. The last two meetings of the Reno County society have been spent in reviewing the organization and aims of the State Assistants Society. At the December meeting of the group Miss Regina Cole will have a paper on "Insurance."

The Shawnee County Medical Assistants Society held a dinner at the Pennant on October 11. Mrs. Florence Linton, program chairmaan, planned a "Bingo" game for entertainment following the dinner and meeting, rather than a program. At a meeting of the Society held on November 8, Mrs. Marjorie Euler, as program chairman, had scheduled two movies "Women at War" and "Raid Over Tokyo."

NOTICE TO MEDICAL ASSISTANTS

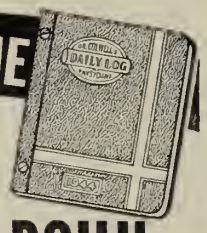
State dues of members of the Kansas Medical Assistant Society are payable to Miss Irene Miller, Gazette Building, Emporia, Kansas. State dues are due on January 1, 1944, and should be paid to Miss Miller as soon as possible.

COUNCIL MEETING

An informal meeting of the Executive Council of the Kansas Medical Assistants Society was held in Hutchinson on November 14. Mrs. Florence Linton's resignation as Councilor was accepted and Mildred McClure of Kansas City was appointed to fill the unexpired term of office of the Councilor for District I until election can be held at the next annual meeting. Bessie Parker tendered her resignation as President-Elect of the society. The 1944 annual meeting was discussed.

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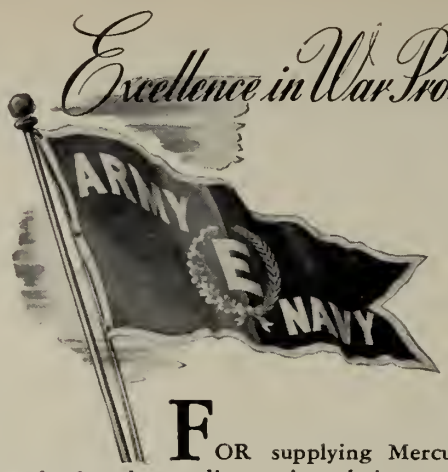


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AUXILIARY

PRESIDENT'S MESSAGE

The time is slipping around to the date when all our Auxiliary dues must be in the hands of our state treasurer. As you know all county dues are to be collected by December 15 and sent to the state secretary immediately as she must have them in the hands of the state treasurer by January 15 . It is necessary to send two copies of the roster of the paid members with the dues. Also will you please send a list of addresses of the wives of doctors in service who have moved to another state, when you send in your dues, or at any time when there is a change of address.

In November or December we will probably be asked to assist the state and district Nurses Association in the registration of graduate nurses, regardless of age or position. The government and hospitals desire the information concerning the number of women capable of assisting their own community in case of an emergency. I urge all Auxiliary members to volunteer their help when this program is announced.

Your Hygeia chairman has the instructions concerning the Hygiea contest. We trust Kansas will get her share of the $400 prize money offered. Each member can help her Auxiliary in this project. Through December and January doctors or their wives may place as many subscriptions as they desire for one-half price, that is $1.25 per year. I cannot think of a more valuable Christmas present for a young mother than Hygeia.

This fiscal year is half gone. It would be a splendid thing for each state and county officer and chairman to check on her duties now to see that everything is functioning as it should. This check will help each to have a better report to send to the state officers next March.

The National Legislative chairman is very anxious that every doctor's wife study specifically the Wagner-Murray-Dingell Bill, S. 1161: H. R. 2861. An analysis of this bill is in the June 26, 1943 issue of the Journal of the American Medical Association. We cannot discuss this bill intelligently with the public unless we know what it contains and purports to do. Many citizens are as concerned about it as the physicians. They are eager to learn more about its objectives and how such a mammoth amount of money that this bill requires will affect them.

Your President will attend the regular meeting of the Board of Directors of the Woman's Auxiliary on November 19, at the Palmer House in Chicago.

Sincerely,
Mrs. E. E. Tippin
Pres. State Medical Auxiliary

AUXILIARY NEWS

The Women's Auxiliary to the Wyandotte County Medical Society met at the home of Mrs. L. M. Nason in Kansas City on November 19. A one-o'clock luncheon was served. Mrs. F. F. Kimball spoke on the subject "Can We Have a Just and Durable Peace" and a general discussion followed.

The fall meeting of the Women's Auxiliary to the Sedgwick County Medical Society was held on October 11. Mr. Oliver Ebel, executive secretary of the county society gave some interesting news flashes on medical subjcts and Mrs. L. E. Knapp discussed "Alice in Wonderland, 1943." It was decided to hold three social meetings during the year and that the regular meeting time be spent in rolling bandages at the Red Cross office. Mrs. C. N. Johnson was appointed War Chairman for the coming year.

The Women's Auxiliary to the Saline County Medical Society entertained with an all-hostess dinner at the home of Mrs. Leo J. Schaefer in Salina on October 14. Dr. Leo J. Schaefer extended greetings from the county society and announced that their Saline County Society would pay the dues of its Auxiliary membership for the coming year. Lt. Col. Warren Bowers, surgeon at Camp Phillips Station Hospital spoke on "Medical Practice in the Army". Capt. George Dyer, physician at the Smoky Hill Army Air Field spoke on "Flight Surgery". Two enlisted men from Camp Phillips furnished violin and piano numbers. The organization has accepted the membership of eleven wives of Army physicians who it is believed will add new interest to the organization. The officers of the Saline County Auxiliary are as follows: Mrs. Leo J. Schaefer is the new president; Mrs. H. E. Neptune the vice-president; and Mrs. E. M. Sutton the secretary-treasurer.

What are the rest of the county Auxiliaries in Kansas doing? Send your "doings" to Mrs. E. R. Millis, 1517 Minnesota Avenue, Kansas City, Kansas.

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INDEX TO ADVERTISERS

American Optical Company VI
Balyeat Hay Fever and Asthma Clinic III
Bosworth, A. H. (Braces) 387
Camel (R. J. Reynolds Tobacco Co.) 383
Camp Company, The S. H. VII
Coca-Cola Company 388
Cook County Graduate School of Medicine . . 385
Corn Products Refining Company 390
Cowell Publishing Company 392
Elms Hotel 386
General Electric X-ray Corporation IX
Grandview Sanitarium 387
Hanicke Mfg. Company, The P. W. 390
Hynson, Westcott & Dunning, Inc. 392
Isle Compny, The W. E. 386
Lattimore Laboratories III
Library Univ. of Kansas School of Medicine . . 386
Lilly and Company, Eli XII
M. & R. Dietetic Laboratories 391
Major Clinic 389
Mead Johnson and Company XVI
Medical Protective Company 387
Menninger Sanitarium and Southard School . . 393
Nestle's Milk Products, Inc. 381
Oakwood Sanitarium 385
Ortho Products, Inc. XIV
Parke, Davis and Company V
Philip Morris and Company 395
Physicians Casualty Association 385
Quinton-Duffens Optical Company 389
Ralph Sanitarium 382
Robinson Clinic 394
S. M. A. Corporation XV
Smith-Dorsey Company, Inc. 384
Smith, Kline & French Laboratories XIII
Spencer Corset Company, Inc. 396
Swope Radiological Clinic 386
Trowbridge Training School 388
Wyeth, Inc., John and Brothers II
Winthrop Chemical Company, Inc. XI
Zemmer Company, The 382

ADVERTISING NEWS

News from the American Optical Company of Southbridge, Massachusetts, informs us that a total of 2,-412,000 pairs of eye protecting sun glasses and goggles have been delivered so far this year to the Army and Navy by that company.

The General Electric X-Ray Corporation of Chicago has received the second award for excellence of war production. A recent letter from Robert P. Patterson, Under Secretary of War reads as follows: "I am pleased to inform you that you have won for the second time the Army-Navy Production Award for meritorious services on the production front.

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The Journal Of
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Volume XLIV DECEMBER, 1943 Number 12

SERIOUS GUNSHOT WOUND OF THE HIP*

Major M. E. Pusitz**
Lt. R. M. Taylor***

The following case report is presented for two reasons. Firstly—it gives an opportunity to review the prevalent concepts in so far as the treatment of severe gunshot wounds of the hip is concerned. Secondly—some years ago the senior author had to take care of an explosion wound in which the greater part of the buttock and upper posterior thigh was shot way. By the time the patient was referred to the orthopedic service, there had developed severe osteomyelitis in the upper end of the shattered femur, with subsequent suppurative arthritis of the hip, and osteomyelitis of the ilium. All the head and neck of the femur was a loose sequestrum. The patient had been going progressivly downhill. Since there was a large portion of the sciatic nerve shot away, disarticulation was performed rather than excision of the hip. In performing this disarticulation, there was a rather large gaping posterior wound in the buttock, as well as inferiorly, and the flaps hung aimlessly. There was constant contamination with feces, etc., no matter how much care was taken in the handling of the wound. The patient finally succumbed, and it was felt that if there could have been formed some postero-internal protection, the story might have been different. The following case presents the different story.

Very few cases of gunshot fractures of the hip are to be found in the records of a base hospital. This is not because the condition is rare, but rather because the majority of these cases die on their way to the hospital. The proximity of vital organs, such as the bladder, the intestines, and the large blood vessels explains this.

It is very difficult to determine the exact method best suited for an individual case. The following classification is a very practical one.

Group I. These are the less serious cases in which a rifle bullet has struck the hip region after its velocity has been lessened. The entrance and exit wounds may be small, although there may be much shattering of bone. If no large vessel or important organ is injured, the progress is usually good. If there is much fragmentation of bone, there is excessive callus formation which may result in ankylosis of the hip. In any event, in such injuries a very conservative routine is the one desired. It goes without saying that the general treatment of shock and hemorrhage is indicated.

Group II. If the rifle bullet strikes the patient at closer range, with the velocity greater than that of sound, there is a tremendous disruptive effect. As a result, even if the wound of entrance is small, the wound of exit is large and gaping. The fragmentation of bone is much more severe, and small fragments may be forced into various positions in the soft tissues. In these cases, a complete wound excision must be performed and fragments of bone that are loose in the tissues should be removed. If there is much separation of the head of the femur from the rest of the bone, it should be removed at this time so that more efficient drainage of the hip will ensue. With much separation of the head from the rest of the bone, there is no likelihood of union, and it can only act as a sequestrum. The Orr method of treatment is then followed.

Group III. Fragments of shell or bomb give a similar picture to the above except that there is more apt to be a carrying in of foreign material into the wound, much more laceration of tissue, and more fragmentation of bone. The wound of entrance and the wound of exit are large, irregular and gaping. Then there are the wounds which occur over the posterior aspect of the buttock and hip, as the soldier is prone or crawling, where a portion of the buttock is scooped out including bone and soft tissues. In such instances, large blood vessels may be spared, but the sciatic nerve is torn apart or a portion of it actually carried away. There are serious cases and must be treated immediately.

In those cases in which there is no destruction of the sciatic nerve, or in which it is determined at the time of the wound examination and toilette that

*Surgical Service, Hammond General Hospital, Modesto, California.
**Chief, Orthopedic Section, Hammond General Hospital, Modesto, California.
***47th General Hospital, Modesto, California.

there is a good likelihood of bringing the ends of the nerve together by suture at that time or in the future, it is unnecessary to consider disarticulation of the hip. A thorough and painstaking toilette of the wound is done with the complete excision of all devitalized tissues, particularly the muscle tissue. Very little of the skin need be sacrificed. Loose fragments of bone should be removed. In these cases there is usually much separation of the head from the rest of the bone and therefore it should be removed immediately. This not only removes bone which has been robbed of its circulation but also allows adequate drainage of the hip. The operative approach will be in a large degree dependent upon the location of the large wound. If this is posterior, then a modified Ober operation may be used. If the large wound is anterior, then a modified Smith-Petersen approach may be used.

Resection of the head of the femur in these serious gunshot wounds of the hip and buttock with much fragmentation and separation of the head is the best procedure to adopt. Sulfanilamide powder is used in the wound, followed by sulfonamide therapy by mouth. The Orr routine is adopted.

Later when all infection is cleared and all the wounds healed, if there is instability of the hip, one can consider some form of reconstruction or arthrodesis of the hip.

Group IV. In more serious cases where there has been so much destruction of tissues, and particularly where a large portion of the sciatic nerve has been lost, there is no question but that sooner or later a disarticulation of the hip will have to be performed. It is difficult to agree with Trueta that it is best to perform an immediate disarticulation of the hip. In the first place, primary amputation at the hip joint in these severe gunshot war injuries carry such a high mortality that it can only be warranted in unusual situations. In some instances there may be no choice so that an immediate disarticulation may have to be performed. This depends upon the individual situation. Certainly in the case herein reported, it was preferable to follow along the lines adopted. What is necessary is the immediate treatment of shock and hemorrhage; the toilette of the wound as above described; and if possible the removal of the head of the femur. As a general rule, the head of the femur can be very easily removed in the severe injuries of the buttock without causing very much additional shock. The use of sulfonamides and the Orr method of treatment give the surgeon an opportunity to bolster the patient until such time as an operation of the magnitude of a disarticulation can be performed with a large enough margin of safety as to warrant it.

CASE REPORT

On October 19, 1942, G.R. sustained a shell wound while in the South Pacific, to the region of the posterolateral right hip and buttock, resulting in compound, comminuted fracture of the neck of the right femur with destruction of about four centimeters of the upper third of the right sciatic nerve.

Sulfonamide therapy was started. He received first aid from a Medical Corps man, his pants being cut away and first aid dressing was applied to the bleeding wound. This treatment was followed by the application of a Thomas ring splint. From this aid station, he was evacuated directly to a field hospital where his wound was redressed. The next morning, October 21, 1942, he was evacuated by air to a base hospital.

On the night of October 21, 1942, he was taken to the operating room, where, under spinal anesthesia, his fracture was reduced and skeletal traction was attained by use of a Steinman pin through the upper end of the right tibia. Likewise, at this time, simple debridement of the wound was performed followed by whole blood transfusion.

On October 23, 1942, with the right lower extremity still immobilized in a Thomas ring splint, he was evacuated to the Islands on a hospital ship. While on this ship, on October 24, 1942, a double hip spica cast was applied also followed by a whole blood transfusion. Another whole blood transfusion was again administered on October 29, 1942.

From November 1, 1942, to January 27, 1943, it was necessary to change spica casts with reapplication five times due to the profuse purulent drainage from the extensive wound of the right hip and buttock. The pin was removed from the tibia, January 10, 1943.

On January 27, 1942, the patient's right leg was put up in a simple long leg cast for the purpose of evacuation from the Islands to LGH where he arrived on February 8, 1943. On February 10, 1943, a simple hip spica cast was applied. Then again, on February 25, 1943, a double hip spica cast was applied, which cast was removed in order to operate upon the wound, which procedure involved simple debridement with establishment of adequate drainage, followed by Dakinization of the wound.

On March 8, 1943, the patient was transferred to HG hospital in a simple hip spica cast. Upon admission to HG hospital, physical examination revealed a very pale, debilitated, twenty-nine year old male, complaining of pain from pressure sores within his cast, which was stained from drainage and from which emanated the foul odor of B. coli pus.

Following removal of the cast, a vertical wound approximately twelve centimeters in length on the posterolateral aspect of the right hip and buttock was revealed. The entire right lower extremity was moderately cold, pale, and completely paralysed; the only movement of which the patient was capable was very weak flexion of the toes; loss of sensation of the right leg was likewise almost complete. About the right heel, periphery of the popliteal fossa and over the sacrum were deep, infected, pressure-trophic ulcerations. Those about the posterior right knee joint had penetrated through the subcutaneous tissue, exposing the tendons beneath. The ulcer of the heel had exposed the Achilles tendon.

Laboratory data was as follows:

1. Roentgenological evidence of compound, comminuted fracture of the right femur, with necrosis of the femoral

head; with osteomyelitis of the right femur, posterior ilium, and acetabulum.

2. Red Blood count—3,800,000; hemoglobin—seventy-five per cent; white blood count—17,650; polys—eighty-five per cent.

3. Negative Kahn; negative urinalysis.

Obviously, the patient was in no condition for major surgery, and yet there was definite evidence of locking of pus in the hip and surrounding area. Therefore, the primary indication made at this time was simple drainage of the pus. This was performed, April 13, 1943, under a combination of intravenous and gas and oxygen anesthesia, and the infected area simply opened up. This allowed a rather profuse escape of thick purulent material. The wound was packed with vaseline gauze, and a long leg hip spica cast applied.

This was followed by careful medical management by the ward officer. During the following two weeks, four blood transfusions were administered. The general condition of the patient improved, and reached its peak in about two weeks, and then he began to lose some ground. He was quite emaciated. By this time, the definite decision was reached that it would not be safe to try to save the extremity, particularly since there was loss of a portion of the sciatic nerve.

The old problem was encountered of how to perform a disarticulation with the development of a postero-internal flap, even though the posterior portion of the buttock and upper thigh had been shot away. By this time, there had occurred so much contraction that the edge of the posterior wound was only about an inch or inch and a half away from the cleft of the buttocks.

In those instances in which the patient is received for definite treatment before six to twelve hours have elapsed, the question of wound excision arises. It should be attempted although this will materially enlarge the wound. The object of this wound excision is to enable a flap to be swung posteriorly so as to block off the wound from fecal contamination. Suture may be done by stainless steel wire, which I have found very useful where there is the presence of infection in contaminated wounds. With such a large amount of exposed tissues, it is not worthwhile trying to attempt a primary closure. In this manner the wound is packed open, the open area being made to face quite a distance away from the cleft of the buttocks. The subsequent course of treatment depends upon the particular form of post-wound therapy the surgeon desires.

In wounds that are more than six to twelve hours old and which are obviously badly contaminated, wound excision is no longer advisable. A debridement may be performed and one would now have to wait until the tissues are moderately clean, and the infection at least controlled, before the question of swinging a flap can be considered. But, I believe it should be considered just as soon as it is feasible. It is to be remembered that the use of sulfonamide therapy alone is not adequate, as the above case proved, to prevent or control post-wound infection unless the proper surgical measures are instituted. It is interesting to note that Colonel MacFarlane in the Canadian Army noted that proper surgical measures without the use of sulfonamide are successful. Of course sulfonamide therapy is a useful adjunct.

Obviously in the above case, there was no opportunity to institute immediate surgical treatment.

On receiving the above patient, the first prerequisite was building him up so that he would be able to stand such a major surgical procedure as disarticulation of the hip. Having built him up for this operation, the next question was the particular method of flap formation so as to finally end with the postero-internal flap which makes the subsequent after care of an elective disarticulation so simple.

The position of the patient on the operating table is very important, rather than the operating table. I have the patient extended beyond the edge of the table so hat the buttocks rests on the very edge. Two small accessory instrument tables are placed, one under each knee so that the legs are abducted. If desired, one does not have to have a table under the sound limb although I find it more useful. At operation, the table is removed from under the involved limb and this is held by an assistant. By the assistant flexing the knee and hip, or extending the knee and hip, and abducting or adducting at the hip, the surgeon has complete access to the entire region making the formation of flaps a very simple proposition.

The particular type of disarticulation adopted was a modification of the usual one so well described in General Kirk's book.

The anterior racket incision is employed. The queue of the racket is started at the mid point of Poupart's ligament and runs downward for a distance of four and one-half inches. Through this incision, the common femoral artery and vein are defined after opening their common sheath. It goes without saying that one must be certain that it is the common femoral artery and not the superficial femoral artery which is defined. The common femoral artery is doubly ligated above, clamped below, and then sectioned. The leg is then elevated, and a sterile Esmarch bandage is wound around the extremity, beginning at the toes and ending just below the point of section. In this way as much blood as possible is saved for the patient. The leg is then lowered and the vein doubly ligated, clamped, and then sectioned. With the assistant manipulating the extremity as recommended above, it is a simple procedure to plan the flaps. The incision is continued from the lower end of the queue medially and downward but swinging gradually to a point about five inches below the groin on the inner aspect of the thigh. This incision is then continued posteriorly to meet the medial edge of the posterior wound and the

buttock. From the lower end of the queue, the incision is swung laterally to about three inches below the greater trochanter and then curved backward to meet the lateral edge of the posterior wound.

With the flaps outlined as above, one can then proceed in the usual manner. The medial portion of the incision is deepened, sectioning the pectineus muscle. By abducting the leg, the adductor muscles are put on stretch and are sectioned not very far from their origins. The incision is deepened posteriorly. The leg is then adducted and internally rotated which enables the sectioning of the tensor fasciae femoris and by deepening the incision, one can section the muscles inserted into the upper margin of the greater trochanter together with the gluteus minimus, pyriformis, obturators, gemelli and the gluteus medius. The leg is then adducted and externally rotated and the hip joint opened by transverse incision. When this was done, the necrotic head and neck popped right out. The iliopsoas tendon was cut at its insertion into the lesser trochanter. The upper end of the femur was then grasped, drawn forward and outward, and with a long amputating knife, the remaining muscles and soft parts were cut in an oblique manner so as to come out at the flap incisions. The bleeding points were clamped and tied. On reaching up posteriorly behind the acetabulum, a fairly large sequestrum evidently coming from the ilium was encountered and removed. There had evidently been an abscess over the ilium above the acetabulum, for the bone could be felt to be exposed and roughened in this region. All the muscle tags and ligamentous tissue were removed from the region of the acetabulum. The usual nerves were isolated, tied with cat gut, injected above the tie with absolute alcohol and divided below it.

Attention was then paid to the fashioning of the posterior wound of the buttock and thigh. The edges were excised and exuberant granulation tissue removed. This left two flaps, namely, an antero-internal and an antero-external which did extend slightly posteriorly. The circulation of these flaps was excellent and the tissues seemed quite healthy. Both flaps were swung posteriorly and sutured so as to obliterate the entire posterior wound opening, the suturing being done by stainless steel wire. When these flaps were sutured, there was a resultant formation of a large postero-internal flap which completely closed off the disarticualtion wound from the cleft in the buttocks and the opening was facing antero-externally.

Adhesive strips were then applied over this posterointernal flap and arranged in such a way that when the conjoined end of these strips was drawn upward over the abdomen, the wound was placed on antero-external facing. Four Dakin tubes were inserted into the depths of the wound, taking care to reach each pocket. Vaseline pack was applied and the skin protected by vaseline gauze.

The typical Dakin treatment was instituted in which each tube is irrigated.

The patient not only stood the operation very well, but made a very excellent recovery. The sutured wound posteriorly healed without any difficulty and the sutures were removed at the end of three weeks. The antero-external wound gradually became obliterated by granulation. With the healing of this wound, there developed a surprisingly good stump which I believe will be useful for tilting table prosthesis, after some plastic work. The only complication encountered was "phantom pain."

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Salvaging in Hospitals—During these times when all staple supplies are becoming scarce, hospitals will contribute materially to the relief of the scarcity by taking an inventory of their attics, storerooms, and other places where obsolete or damaged supplies are stored.

It is increasingly important that hospitals salvage waste metals, ferrous and nonferrous, brass, copper, alloy, aluminum, white metal, lead, tin, and zinc. Every hospital has varying amounts of this sort of material which should be scrapped and salvaged for war uses. Old iron and steel, unused and practically useless, will be found in considerable quantity in every hospital. The best possible use that can be made of it is to dispose of it for our war needs.

Rubber is one of the most critical materials at the present time. Damaged articles of rubber, gloves, ice and water bags, hose, fountain syringes, catheters, rubber sheeting and old tubing should be repaired if possible or carefully salvaged for reprocessing. Each hospital will find it has sizeable quantities of old rubber.

Worn-out woolen blankets and rugs and carpets with high wool content should be salvaged. Feathers, if originally of good quality, should be recovered, cleaned, and used again. Old rags and paper should be saved and sold to dealers. All of this salvage will help to relieve a shortage which is becoming more acute.

Nothing useful should be destroyed. When it is beyond repair, it should be salvaged. Nothing should be wasted. Wherever possible all articles should be patched or mended and made to serve as long as possible. In the aggregate, a large quantity of critical materials will be salvaged in our hospitals. We should cooperate cheerfully and continuously with the nation-wide "Salvage for Victory" program.

Buy United States War Bonds and Stamps

"SCREW WORM" INFESTATION OF THE EAR

Ralph R. Melton, M.D.

Frederick W. King, A.B.*

Marion, Kansas

CASE HISTORY

The patient, M.V., a farmer's wife, age fifty-eight, on September 30, 1943, complained of a painful and discharging left ear. She had been bothered since 1914 at times with drainage from this ear. As a child of twelve, a bug flew into her ear while she was a resident of Czechoslovakia. She reports that she received no medical attention until about one year later when a physician irrigated the ear and removed parts of the insect. September 28, 1943, she began to experience some discomfort in the left ear and on September 30, the day of the examination, the canal was occluded by a purulent exudate, which after being removed, showed a destruction of the ear drum and scarring of the canal. The external opening of the canal was considerably dilated due to the use of a cotton ear plug continuously for several years.

The diagnosis was chronic otitis media and treatment was instituted by local application of a five per cent suspension of sulfathiazole and sulfathiazole by mouth. An analgesic was given for the pain. On the night of October 1, she complained of more pain and reported that there was a bloody discharge from the ear and considerable roaring in her head. An increase in the amount of her analgesic was advised and the application of heat was recommended; she was advised to report for examination the following morning. October 2, 1943, she reported for her examination and complained of pain and much roaring in the left ear. The roaring was increased by the application of heat to the point of intolerability during the night. Examination revealed a blood tinged purulent exudate filling the canal. The canal was cleaned for inspection. There seemed to be a rhythmic movement similar to the pulsation of a blood vessel in the canal at the position of the drum. This movement naturally attracted our attention and we observed it for awhile and during the observation there appeared to be a purulent exudate flowing from the middle ear which soon appeared to begin to flow back into the middle ear. It then occurred to us that the pulsation that we noticed was not that of a blood vessel, but that of something crawling into the middle ear. We immediately irrigated the ear without results. Examination of the drum after irrigation confirmed our opinion that this was a worm or a larva and by the use of a reflected light and forceps the object was grasped and withdrawn.

The identification of the worm or larva was obvious as that which is commonly referred to as a "screw worm." The larva was approximately one centimeter long and four millimeters in diameter and very actively motile, grayish-white, pointed at both ends, but more pointed at the head, having approximately twelve rings of minute spines which appeared as the threads of a screw. The head had a tough horny, oral hood. The patient experienced immediate relief of the pain and of the roaring in her ear upon removal of the larva. She was questioned regarding whether she had felt an insect in the ear recently, but could not remember of any such occurrence, but added that she always wore an ear plug. The husband was questioned whether he had any animal infested with "screw worms" and he reported that he had been treating the condition in a calf. The fact that this patient had an insect of some sort in her ear in 1914 was regarded only as the causative factor of the otitis media and was not regarded as the fly that had deposited the egg of the larva.

We felt that because of the presence of one larva others could be expected to be found. She was admitted to the hospital and there the ear was insufflated with chloroform fumes under pressure, using the ether vaporizing mechanism of a suction apparatus and a glass nasal tip to fit the external auditory canal. This was done every four hours and the ear plugged with a cotton plug which had been moistened with chloroform. She experienced no further discomfort except slight burning on the application of the chloroform soaked plug. She was able to leave the hospital the following day. She was instructed to apply a chloroform soaked plug to her ear twice a day and to report if she experienced any roaring or other symptoms referable to her ear.

On October 5th, she came for examination stating that she thought she heard some roaring in her ear. Examination revealed nothing that would resemble a larva. The canal, however, was partially filled with a clear watery exudate that contained many bubbles of air. This was cleaned and a cotton plug soaked in benzene was applied to the ear. The patient was instructed to continue to use the chloroform soaked plugs and to report at any time that she had any untoward symptoms referable to her ear.

She was seen on October 7 and 14 and no larvae were found. On October 14 she was permitted to discontinue the use of the chloroform plugs. We felt that sufficient time had elapsed for any eggs that might possibly be deposited there to have hatched, and since no more larvae were found our conclusions were that any eggs that may have been present had

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been washed away in the exudate during the irrigations that we performed.

MYIASIS

Myiasis is the name applied to the diseases or symptoms produced by fly larvae when they live parasitically in the bodies of man or other mammals.

The "screw worm" is scientifically referred to as the larva of the fly *Cochliomyia macellaria* Linn. This is a rather widely distributed fly and it occurs in all parts of the United States. The larvae are frequently deposited in the wounds of animals and are responsible for great losses of livestock in the United States. The control of this fly constitutes a major problem in animal husbandry and has been made the subject of study by federal authorities over a period of years. The fly is a greenish blue calliphorine species, an obligatory parasite of warm blooded animals, breeding in nature on living animals and capable of penetrating unbroken skin. This species is found in ninety per cent of myiasis producing wounds in man and animals in the middle Western and Southern parts of the United States. The adults have a flight range of at least nine miles in a single summer and the flies may migrate as far as 1,500 miles north of their over wintering zone. These flies winter in the Southern part of the United States, and especially in Texas. They cannot survive the year around where the average temperature is fifty degrees or lower for a continuous period of eighty days or longer. The eggs are deposited by the fly in batches of 50 to 300. The female is capable of laying 3,000 eggs in her season. It requires from six to twenty-one hours for the eggs to hatch into the larvae. The larvae feed ravenously from four to ten days in the exudates of the wound of the living animal and then drop to the ground where they burrow into the soil and remain from seven to seventy-six hours before entering the pupal stage. The pupal stage requires seven to fifty-four days before the fly emerges, completing the life cycle. In warm weather the cycle is completed in twenty-one days. Thus it can be seen that several generations of flies may hatch in a single summer.

The larva or "screw worm" is approximately one centimeter long and four millimeters in diameter, grayish white and pointed at the head. The body is encircled by approximately twelve cartilaginous rings, thus giving the worm the appearance of a screw. The larvae penetrate by means of powerful mouth hooks. In the nasal and aural cavities the larvae may burrow into the tissues, devouring in their passage all structures including mucous membrane, muscle, cartilage, periosteum and even bone. They may penetrate into the brain and cause death.

Clinically, myiases may be classified according to the part of the body invaded by the larvae, into:

1. Cutaneous myiasis—when the larvae live in or under the skin.
2. Intestinal myiasis—when the larvae are in the stomach or intestine.
3. Cavity and wound myiasis—when the larvae invade natural (naso-pharynx, frontal sinuses, aural) or artificial (wounds) cavities in the body.

The degree of injury resulting from myiasis depends upon the location and number of larvae and also upon their feeding habits. The larvae which are parasitic do not cause the death or serious illness of their host unless they are present in unusual numbers or accidentally reach an unusual location. In most species, the larvae normally live in decaying meat and are only found occasionally as parasites. In such cases where they are found as parasites, extensive tissues-destruction occurs, and serious injury or even death may easily supervene unless the larvae are removed.

The *Cochliomyia macellaria* Linn or *Americana* larvae are frequently the species found as parasites and the resultant lesions can produce frightful injury. A mortality of eight per cent has been reported. Although the fly is capable of penetrating unbroken skin, the odor of suppuration seems to attract them. Patients with otitis media should be advised to keep a cotton plug in the ear while outdoors and around animals, especially during the fly season.

The larvae are readily killed by chloroform or benzol. If chloroform is used it should be used in the form of a vapor if possible or in the fluid form applied directly or on cotton soaked plugs if necessary.

Turnbull and Franklin in California reported in the Journal of the American Medical Association, a case report in which a woman, with chronic otitis media was walking across a grassy field at Bryce Canyon, Utah, felt an insect enter her ear about noon and remain there for approximately two hours before she felt it leave. About midnight of the same day she was awakened by a buzzing in the ear and noted that a watery bloody discharge was coming from the infected ear. The buzzing continued until about three o'clock the next afternoon, when she was seen by one of the writers who on examination of the ear noticed a white larva. Upon irrigating the ear they obtained four larvae. Two hours later, or about 5 o'clock, the buzzing began again and four more larvae were obtained. Later that evening nine more were flushed out. During that night, and the following day, the ear was irrigated several times and thirteen more larvae were obtained. The next day four more larvae were obtained, making a total of thirty-

(Continued on Page 407)

President's Page

To the members of the Kansas Medical Society:

Recently a man made this remark to me "I'll not buy a bond as long as we have these new dealers in Washington."

This man completely missed his, your and my obligation in this war. Regardless of what we might think of politics, most certainly the most important thing in our lives today is to win this war. You and I at home, most certainly have not sacrificed as has Dr. W. E. Wilson of Greensburg (now a captive of the Japs), Lt. Col. R. D. Grayson of Overland Park, Lt. Sherburn MacLeod of Wichita and many other doctors who have recently been invalided home from foreign service. You hear groups that are willing to criticize every action of our war leaders, yet they know none of the background, none of the reasons or plans for certain activities.

I would like to see our medical profession in Kansas take the lead in backing our government in every one of its war efforts. Let us take a lead in our local communities in every war program, Red Cross, war bond drive, plasma bank, U.S.O., various aid programs and the many other calls that will be made upon us. If this war is lost there won't be a Kansas Medical Society, there won't be any private practice of medicine, so we can sit around and refuse to cooperate in our war effort. This is just exactly what our enemies would like.

We are all busy but we are not putting in the hours that some of those boys have put in, in Sicily and the Southwest Pacific. So let's take an attitude of willingness to do our part in every way, financially, personally, and patriotically.

A dentist in Topeka, only last week went in to pay his income tax and as he left the building feeling sore at the world for having to pay so much, he met another dentist and the first was informed that Tommy Capps (a young Topeka dentist) was just lost on the Liscombe Bay and the first dentist said that he felt like a heel for being sore at the world about his income tax.

Can we Americans take it?

Sincerely,

J. L. Lattimore M.D.

President, The Kansas Medical Society

EDITORIAL

KANSAS SOCIETY TO HOLD 1944 SESSION

The Kansas Medical Society will hold its 1944 annual session in Topeka on May 11 and 12. The decision was made by a vote of the officers and councilors of the Society recently and plans for the meeting are going forward.

Under ordinary circumstances the meeting would have been held in Wichita this year but due to the crowded facilities of that city it was decided to hold the 1944 meeing in Topeka. The program for the scientific session and plans for the technical and scientific exhibits are well under way. Additional information on the May meeting will be published in later issues of the Journal.

It is believed the meeting will be well attended due to the cancellation of last years meeting and to the desire of our doctors in the state to keep well abreast of the scientific knowledge of the day. Begin to make your plans now to attend the whole meeting, since you can do this with only two days absence from your practice.

DOCTOR PROBLEMS

The following items of interest to the medical profession in connection with the war and the post-war period were gleaned at the recent meeting of secretaries and editors in Chicago. The needs of the armed forces for the remainder of the war will be 6,000 more doctors every nine months and 1,200 of these will be replacements of medical officers killed or receiving discharges. Two years from now there will be a serious shortage of doctors both for the Army and the civilian population if the war is still in progress. The Army needs 5,000 to 7,000 more doctors now. Also if the war ends in 1945 there will be released 20,000 doctors who have had no previous experience in the private practice of medicine. The majority of these men will have had only nine months interne training between graduation and their military service. A great opportunity and a sacred duty lies with organized medicine in helping these men to prepare for private practice and secure locations. The Post-War Planning Committee in each state can be of great service in providing further training through residencees, refresher courses and specialty training. There are also problems to be solved of relocation and providing medical services in sparsely settled districts where some form of subsidy may be necessary.

The Planning Committee should be entirely separate from Procurement and Assignment in order to bring in new blood and a fresh viewpoint to the new challenge. We hope that Kansas thru its committee will take a commanding place in this work.

AMERICA MUST NOT BE SHACKLED

The Hon. Joseph W. Martin, Jr., of Massachusetts, in an address before the Fifteenth Annual Scientific Medical Society of the District of Columbia held in Washington, D. C., in October, had the following to say regarding the proposed legislation and the need to sustain the American way of life, which it is believed will be of great interest to every member of the medical profession.

"Every one of us has a definite interest in seeing that every child, every woman and every man secures adequate medical aid and care. We can and we will, as a government, discharge our full obligations to the sick, the aged, and the unfortunate, unable to pay their own way. But we must do it in the American way—in a way which will preserve the spirit and

Announcing the

85th Annual Session

of the **Kansas Medical Society**

Topeka, Kansas *May 10-11-1944*

the initiative of the men and women of your profession. They must be encouraged to go ahead with studies and experiments; to make new and greater scientific discoveries for the benefit of mankind. And we must care for our ailing ones in such a way that every patient will not be a ward and pawn of an all-powerful state.

"We must not shackle your great profession and restrict the service it can give to the world. If we give to some bureaucrat the power to regulate the practice and fix the fees of a physician and to govern the hospitals, we will shackle the science of medicine. We must make sure every man and every woman retains the right to select the doctor of his or her own choice. That has been a great American right and the people of this country want to keep it.

"To place the practice of medicine under bureaucratic control would not affect medicine alone; it would constitute a long forward step in putting the other professions and all American labor, industry, and agriculture permanently under the direction of a Washington bureaucracy. By whatever name we might call it, it would be a form of state socialism."

MOBILIZING OUR HOSPITALS

The article by Harry Hopkins, condensed in the February Readers Digest, should be carefully read by all hospital authorities. Many will disagree with Mr. Hopkins, both as to the argument and to the conclusions, but he is unquestionably right in his premise that manpower, materials, processing, manufacturing and all other resources of our country must be mobilized under competent control if our war is to be won and won speedily.

And hospitals must do their part. While there is no good reason why they should be regimented, there is every reason why their individualistic tendencies should be directed toward cooperative purpose and coordinated action. This applies to medical and nursing education, to uniform purchasing procedures, standardization of supplies, community of interests, sharing of staff services, and the multiple activities in which hospitals are engaged in the care of their patients. Hospital performance and hospital purpose must be mobilized because of the increasing patient load they will have to carry. In these trying times our hospitals must understand and willingly apply the principles of mobilization of their resources to the end that proper care will be provided for our people. Now, more than ever, each hospital is its "brother's keeper."

Hospitals must have a reasonably free hand in making salary and wage adjustments for their employees if they expect to retain a sufficient number of employees for essential hospital services. The employee turnover in hospitals, due to a low wage and salary scale, has impaired the patient service in every hospital in the country, whether private, voluntary, or tax supported. The only remedy that promised stability of employee tenure was a regulation as wise and as liberal as the War Labor Board has established.

The group exemption for hospitals is the first blanket exemption authorized by the War Labor Board. Its ruling was the result of arguments presented by the Joint Advisory Committee, by the Council on Government Relations of the American Hospital Association, the joint action of the California hospitals, and the hundreds of requests coming from individual institutions, presented to the Regional Boards as well as to the War Labor Board in Washington.

Hospitals under the new order are required to submit monthly reports of their wage adjustments to the Board's division of review and analysis.

The action of the Board is entitled not only to the commendation of all hospitals, but to the cooperation of the hospitals by carefully following the purpose of the regulation. It is a further evidence of the central authorities willingness to cooperate with the hospitals in their effort to maintain an acceptable service for the care of the increasing number of patients.

While hospitals cannot hope to meet the high wage scale of war industry or compete with industry in the remuneration of their employees, they can accomplish much in maintaining a reasonably stable staff by establishing wage and salary increases where justified and re-adjusting the wage scales in line with increased living costs. The increased earnings of our hospitals could not be spent for a better purpose than by establishing an equitable and as liberal as possible remuneration for their employees. —Hospitals.

Dr. Philip Levine of Newark, New Jersey, announced to the Congress on Obstetrics and Gynecology the discovery of a new factor in red blood cells which accounts for hundreds of infant deaths before or soon after birth. It is a mysterious substance which makes babies poison their mothers and, in a reaction, kill themselves. The principal use of the discovery to date is in testing the blood of the mother, who may require a blood transfusion during or after childbirth.—Journal of the Michigan State Medical Society.

Army, Navy, industry, public health—all must fight together and against tuberculosis. Charles E. Lyght, M.D., Amer. Rev. of Tuber., Sept., 1942.

TUBERCULOSIS CONTROL

CANCER OF THE LUNG — A GROWING PROBLEM

There is a masquerading lung disease which often gives quarter for a short time before the fatal issue and whose actions, in many ways, may simulate those of tuberculosis.

Both diseases are unique for they masquerade as other acute or chronic conditions of the lung. In neither are symptoms reliable in the early stages. Both disease are marked by a lack of early reliable physical signs. Both are unique since in the early stages a single x-ray film will usually show some abnormality. Again, they ape one another because in spite of obscure clinical factors the diagnosis can be accurately made in a high percentage of cases. Lastly, there is a similarity between tuberculosis and this masquerading disease, cancer of the lung, as successful treatment depends to such a large degree upon early discovery.

However, the two diseases are different as regards the predominant age groups affected. Tuberculosis concerns principally the age groups between fifteen and forty, whereas lung cancer usually affects those between the ages of forty and sixty-five. The diseases are totally different in respect to the matter of time. In tuberculosis, time plus rest is often a useful ally of the patient in regaining health. In cancer of the lung the element of time is always an enemy of the patient. Prolonged observation and rest treatment never improve the situation, but rob the patient of his only chance for possible cure.

In 165 cases of lung cancer it was found that they first consulted a doctor because of symptoms usually associated with almost any chronic chest condition. A review of these symptoms suggests it would be impossible to set apart any group of complaints that could be regarded as pathognomonic of pulmonary malignancy. Nevertheless, eighty-two per cent of all the patients reported chronic cough, while no less than ninety-two per cent had as a first symptom something that called for attention to be directed to the chest when first the physician was consulted. Besides cough, other common symptoms included chest pain, chills and fever, hemoptysis, dyspnea, loss of weight and weakness.

Reviewing the physical signs elicited it is again impossible to outline a specific and significant grouping any more suggestive of cancer than of other chronic pulmonary conditions. Cases examined in the early stages often presented no physical signs. When present, the signs were of considerable variety and frequently misleading. They included evidence of congestion, consolidation, fluid, localized emphysema, cavitation, bronchial obstruction, mediastinal shift and other phenomena varying with the case, thus emphasizing the unreliability of simple physical signs in the differential diagnosis of this condition.

Of the 165 cases, 104 (sixty-three per cent) were incorrectly diagnosed by the first doctor consulted. In view of the confused picture of misleading symptoms and physical findings, perhaps this majority in favor of error is not completely surprising, but the sobering thought emerges that treatment based upon an erroneous diagnosis was maintained for long periods of time, aimed at such supposed conditions as tuberculosis, forty cases; unresolved pneumonia, eighteen cases; lung abscess, thirteen cases; bronchitis, eleven cases; asthma, five; heart disease, four; pleurisy, four; metastatic tumors, two; and miscellaneous, nine cases. Most notable fact was the high frequency of false diagnoses of tuberculosis.

Unfortunately, lung cancer was not unmasked in far too many cases until long after the patient first visited a physician. It was possible in 125 case histories to determine how speedily a verified diagnosis was reached. Two facts stood out boldly. First, thirty-six per cent of the patients placed themselves under medical supervision at onset or within one month of the onset of symptoms. Second, the average patient consulted a doctor within three months of onset but did not receive benefit of a chest x-ray for an additional three months. The true diagnosis was not arrived at until nine months had elapsed from the time when the first doctor saw the patient.

The x-ray, without doubt, is by far the most valuable aid in apprehending pulmonary disease, but a distinction is necessary between its ability to yield presumptive and absolute evidence. In ninety-eight per cent of this series of cases the initial film revealed trouble was present. An explanation of the delay in reaching a final diagnosis may be found in the fact that in the majority of instances the primary pathological process failed to produce upon the film or the fluoroscopic screen a shadow of itself. Those abnormalities that did appear were secondary effects due to the presence of the neoplasm and were of such variability as to be susceptible of a wide range of interpretation.

In ninety-five per cent of the cases it was possible to establish an unequivocal diagnosis during life, bronchoscopy being the leading method of obtaining tissue, and having been employed in 103 cases. In thirty-nine other cases surgical exploration was used. Metastases were sectioned in a few cases, aspiration was the method in another small group, while the

remaining five per cent were diagnosed only after post-mortem examination.

For a decade surgery has been available in the treatment of lung cancer. A creditable showing has been made during this pioneering period. For example, two out of every five cases surgically explored have been found to be free of extension of the cancer extrapulmonarily. The percentage of the entire group of verified cases for whom there was some hope of cure was twenty per cent. This seems an encouraging ratio when we recall that prior to 1933 there was no reason to regard the condition as anything but incurable. As a reward for our efforts, twenty patients, or thirteen per cent, remain as the net salvage from the entire series of 156 verified cases of primary lung cancer, out of thirty-two individuals selected for an attempt at curative resection. These twenty patients are all reasonably well and devoid of evidence of metastatic disease, while five of them can be referred to as "cures" insofar as they have now passed the five-year mark.

In considering practical steps toward bringing cases of lung cancer to light during their curable stage we can learn valuable lessons from the record on tuberculosis case finding. Physicians have been taught that if tuberculosis is to be discovered during its minimal stage it is necessary not to search for absent or insignificant symptoms and physical signs but to go immediately to the x-ray. The same can be said for the apprehension of early lung cancer.

How may the first doctor consulted set in motion this mechanism of early discovery? He may save valuable time for his patient if he remembers:

1. That cancer of the lung is now one of the most important diseases of the chest in patients within the age period from forty to sixty-five years, particularly in males.

2. That many patients do seek help at a time when the lesion is still confined to the lung.

3. That symptoms and signs are either lacking or misleading in the early stages.

4. That the earliest lesions will in almost every case produce some telltale shadow on the x-ray film, and

5. Finally, that there are two methods available for clinching the diagnosis:

First, that the majority of lesions are visible bronchoscopically and accessible for biopsy, and second, that when the suspicion cannot be verified in this way, it is possible to explore the chest safely by surgical means, settle the diagnosis and carry out curative treatment if necessary.—A Common Masquerading Lung Disease, Richard H. Overholt, M.D., Diseases of the Chest, May-June, 1943.

"SCREW WORM" INFESTATION OF THE EAR

(Continued from Page 402)

nine larvae. The patient seemed to have suffered no other ill effects from her experience.

CONCLUSION

A case history of a "screw worm" infestation of the aural cavity and middle ear is reported with a description of the symptoms and treatment. Reference is made to the habits of the larva and of the fly producing the larva.

1. The "screw worm" fly is attracted to the odor of suppuration and is a potential danger to open wounds, especially of suppuration from a normal body cavity.

2. Suppurating wounds and cavities should be covered by a dressing or plugged with cotton at all times in the presence of the surroundings that are suitable to the "screw worm" fly.

3. The "screw worm" is readily killed by chloroform vapors, or liquid form, or by benzol.

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According to figures from the United States Census Bureau published in the newspapers, there were 385,191 deaths from heart disease in 1940, giving a rate of 292.5 per hundred thousand of population and totaling the greatest number of deaths ever recorded from heart disease. The rate per hundred thousand deaths in 1939 was 275.5. The following comparison between 1900 and 1940 shows the sharp decrease in the death rate in the low age brackets:

	1940	1900
Under 1 year	17.5	147.8
1-4 years	3.6	15.0
5-14 years	8.0	23.3
15-24 years	14.0	28.8
25-34 years	29.7	43.4

The increase in fatalities among upper age groups is shown by these figures: 35-44 years, 91.7 in 1940 and 80.8 in 1900; 45-54 years, 279.5 in 1940 and 173.0 in 1900; 55-64 years, 713.5 in 1940 and 414.1 in 1900; 65-74 years, 1,723.5 in 1940 and 957.3 in 1900 and 75 and over, 4,813.2 in 1940 and 1,819.7 in 1900. Federation Bulletin of the Federation of State Medical Boards of the United States, January 1943.

Lawyers are the cleverest men, the ministers are the most learned, and the doctors are the most sensible. — Oliver Wendell Holmes.

MEN IN SERVICE

Lt. Col. Milford T. Kubin, formerly of McPherson, who was recently the executive officer of Winter General Hospital in Topeka, has been named as commanding officer of the Sixteenth General Hospital at Fort Devens, Massachusetts, according to army authorities. Lt. Col. Kubin attended the University of Kansas School of Medicine and the Army Medical School at Washington, D. C. He has served at the following Army hospitals: Fort Leavenworth, Fort Riley, in the Philippines and China, and at Fitzsimmons General Hospital in Denver, before coming to Topeka. He was at the Winter General Hospital when it was dedicated and was transferred to Massachusetts recently.

From Capt. Philip W. Morgan, formerly of Emporia, we have the following: "This is the best break I could ask for. My Medical Corps assistants are good men with the best of personalities and background. The C.O. is a man who really can and does run things, well and smoothly. He couldn't be better. Dr. Charles Moran of Arkansas City is here and was recently promoted to the rank of Major. He has been here for some time. The whole bunch couldn't have treated me better if I was their long-lost brother. How is everything and everybody? Give everyone in the office and Dr. John L., and Dr. Forrest L., my best regards. There are so many whom I'd like to write—it's impossible and I have a stack of unanswered letters on my desk all the time. This is, however, a pretty good job and anyone who says there's a lot of time to loaf—doesn't know this place. We have a good little library in our hospital but it lacks the Journal of the Kansas Medical Society. How about having mine sent here? Extend and deliver my compliments at the next Council meeting." Captain Morgan is stationed at Kelly Field, San Antonio, Texas.

Recent War Department orders: Dr. Lawrence Adrian Proctor of Parsons is ordered to active duty as a Captain in the Medical Corps. Lt. Ronald Curtis Vetter of Lawrence promoted to the rank of Captain; Lt. Marshall E. Christmann of Pratt promoted to the rank of Captain; Lt. Charles Leonard Woodhouse of Wichita promoted to the rank of Captain; and Lt. Eugene Albert Reeves of Kansas City promoted to the rank of Captain.

The central office is in receipt of the following from Capt. Ward M. Cole formerly of Wellington who has an APO address out of Seattle, Washington: "How's everything in a medical way back in Kansas? I've been in the Army over two years now so I'm somewhat out of touch with civilian practice. Have been reading considerable comment pro and con on the Wagner socialized medicine bill. I hope that you're keeping up the fight on such things. The thing that amazes me is that people who have the best medical care in the world will even think of subscribing to such a regimentation. Also the fact that it is being brought up when so many of us are absent and unable to attack this menace is dastardly. However, little else can be expected under the present regime. I believe though that if such schemes are explained to the rank and file of the people, they will fail due to their weakness.

"The Kansas Society is doing an admirable job of carrying on in these times and we who are absent certainly appreciate it. As we who are gone are unable to do anything politically it means that you back there will have to carry a double load. Like many other young doctors, I feel that some sort of hospital or medical insurance is necessary for certain groups. However, such plans to be at all effective and at the same time preserve the high standards of American medicine, must of necessity be administered or controlled by the doctors.

"All the medical officers here enjoy the Journal very much. Thanks for sending it. Keep me advised through the Journal as to the progress of the fight against the regimentation of the medical profession. The Journal is the only means of contact most of us have with our old lives and you'd be surprised how well it is read in these outposts."

Major Virgil Auchard of Lawrence has recently been promoted to the rank of Lieutenant Colonel, and according to newspaper reports is serving in Alaska.

Dr. L. O. Armantrout of Garden City has reported for duty as a Lieutenant in the Army Air force at Carlisle Barracks, Pennsylvania.

Major Farris D. Evans of Conway Springs, son of Dr. E. A. Evans of the same city, is now stationed at Camp Chaffee, Fort Smith, Arkansas.

From Major T. V. Oltman of Newton we have received a V-Mail letter giving us his new address APO New York. He was formerly stationed at Camp White, Oregon.

Graduation exercises were held on October 27 for aviation medical examiners at Randolph Field, Texas, and the following Kansas men were listed as having graduated: Lt. Robert C. Anderson of Topeka; Lt. Carl T. Beuhler, Jr., of Halstead; Capt. Paul E. Craig of Coffeyville; Lt. Oliver L. Martin of Baxter Springs; Capt. George E. Stafford of Salina; and Lt. Ralph M. Wyatt of Hiawatha.

The fifth edition of the Wyandotte County Newsletter came to our desk in October and contained some interesting Men in Service items: "New addresses just arrived for Schulte (Major Emmerich Schulte of Kansas City) and Davis (Capt. C. G. Davis of Kansas City). Schulte writes from England that he is bicycling over the country-side . . . Lt. J. G. Evans of Kansas City is with the Sixth Motorized Division with an APO out of Los Angeles. . . . Bill Algie (Lt. Comdr. W. H. Algie of Kansas City) personally conducted Mrs. Roosevelt through his Ward in the Hospital when she was in the South Seas."

Lt. Milton Lozoff, formerly with the Menninger Clinic in Topeka, is at the Navy Recruiting Station at Milwaukee, Wisconsin.

Lt. C. H. Johnson of Kinsley has been transferred from the School of Aviation Medicine at Randolph Field, Texas, to MacDill Field, Florida.

Lt. Col. R. D. Grayson has recently been retired from the Army, following an abdominal operation. He was returned

from foreign service because of ill health and was for a time at the O'Reilly General Hospital at Springfield, Missouri. He has returned to Overland Park where he plans to resume his practice in the near future.

Lt. H. L. Songer of Lincoln writes that he has been transferred from Camp Robinson, Arkansas, to an APO address out of New York.

Capt. Harold Hyndman of Wichita, recently completed a post-graduate course in anesthesia at the Mayo Clinic.

Lt. L. B. Putnam of Wichita has been promoted to the rank of Captain recently.

Lt. Otis D. Swan of Topeka is stationed at March Field, California.

Lt. Charles C. Pokorny of Attica is stationed at Gardena, California.

Lt. Spencer Boyd of Topeka has received a promotion to the rank of Captain.

Dr. N. C. Nash of Wichita has been commissioned as a Lieutenant and will report to Ft. Benjamin Harrison, Indiana, after taking preliminary training at Carlisle Barracks, Pennsylvania.

Dr. D. A. Bitzer of Washington reports for duty with the United States Navy as a Lieutenant Commander on December 27.

Major Clarence Munns, the former executive secretary of the Society was in the office for a few minutes visit the past week. Major Munns is stationed in Washington, D. C. and was returning after a short furlough spent with his parents in Hoisington.

Dr. J. J. Hovorka of Emporia has been commissioned a Captain in the Army Air Corps and reported for duty on December 11. He formerly practiced in Halstead.

Capt. Charles T. Moran of Arkansas City has been promoted to the rank of Major. He is stationed at Kelly Field, San Antonio, Texas.

Capt. E. G. Neighbor (formerly Lt. Neighbor) of Kansas City according to a recent Kansas City news note is in Australia and on the move. He is a surgeon in a flying unit that goes ahead to prepare the way for invasion.

Capt. S. D. Henry of Kansas City is stationed at Mt. Oliver, Pittsburgh, Pennsylvania, where he is battalion surgeon.

A recent news note carries the following: "The book 'I Served on Bataan' on a page in about the middle of the book is a full sized picture of Captain Wilson (Dr. W. Errol Wilson of Greensburg) in one of the wards in the so-called jungle of Bataan. It is Dr. Wilson with a crew hair cut and looking as fit as a fiddle." No particular mention of Dr. Wilson is made in the book though reference to various doctors who have served in the wards is made.

Dr. R. E. Baldridge of Kingman has been promoted from the rank of Lieutenant to that of Captain in the Army Medical Corps. Capt. Baldridge is stationed at Oklahoma City, Oklahoma.

Capt. F. J. Eckdall of Emporia, stationed for sometime at Leonard Wood is now located at Greeley, Colorado.

Major M. W. Hall of Wichita has been transferred from Ozark, Alabama, to Nashville, Tennessee.

Capt. H. L. Patterson of Lyons has been transferred from Camp Robinson, Arkansas, to Camp Stoneman, California.

Capt. Robert H. Riedel formerly of Topeka has been transferred from Camp Carson in Colorado Springs, to the office of the Air Surgeon in Washington, D. C.

According to the Sedgwick County Medical Bulletin, Lt. Sherburn MacLeod, U.S.N.R., after a trip to the Pacific, has been discharged from the service, due to ill health and is back in Wichita again.

Lt. A. E. Cooper of Logan has informed us that he is reporting for duty with the Navy on December 13 and will be stationed at least temporarily at Great Lakes, Illinois.

Capt. Walter C. Ingraham of Lawrence is now serving in the Mediterranean Area. He left for foreign service in October, 1942.

NEWS NOTES

KANSAS DOCTOR OF MEDICINE HONORED

Dr. Lewis G. Allen of Kansas City was recently elected as President of the Radiological Society of North America at its annual meeting held in Chicago on November 29 to December 3.

Dr. Allen, who is the professor of Clinical Radiology at the University of Kansas School of Medicine, has formerly held several offices in that society, last year being a member of the Board of Chancellors and a member of the Commission on Public Relations.

COMMITTEE MEETING

A meeting of the Post Graduate Activity Committee comprised of representatives of three groups: the University of Kansas School of Medicine, the Kansas State Board of Health and the Kansas Medical Society, was held in Topeka on Sunday, December 12. Those attending were: Chancellor Deane Malott of Lawrence, Dr. Ralph I. Canuteson of Lawrence, Dean H. R. Wahl of the University of Kansas School of Medicine at Kansas City, Dr. H. H.

Jones of Winfield, Dr. F. C. Beelman of Topeka, Dr. J. L. Lattimore of Topeka, Mr. Harold Ingham of the extension division of the University of Kansas at Lawrence and Mr. Robert Brooks.

Dr. H. H. Jones of Winfield has been appointed to succeed Dr. Philip Morgan of Emporia who is now in service.

The committee formulated plans for the continuation of post graduate courses during the year 1944.

APPOINTMENT

Dr. J. L. Lattimore, President announced the appointment of Dr. G. M. Edmonds of Horton as chairman of the Society Committee on Study of Heart Disease to succeed Dr. Philip W. Morgan of Emporia. Dr. Morgan entered service in the United States Army recently and announced his resignation as chairman of that committee.

PURPOSE OF COUNCIL ON MEDICAL SERVICE AND PUBLICATIONS OF A.M.A.

The Journal office is in receipt of the following information in regard to the purpose and function of the Council on Medical Service and Public Relations of the American Medical Associatioin which it is believed is of interest to the members:

1. To make available facts, data and medical opinions with respect to timely and adequate rendition of medical care to the American people:

2. To inform the constituent associations and component societies of proposed changes affecting medical care in the nation;

3. To inform the constituent associations and competent societies regarding the activities of the Council;

4. To investigate matters pertaining to the economic, social, and similiar aspects of medical care for all the people;

5. To study and suggest means for the distribution of medical services to the public consistent with the principles adopted by the House of Delegates, and

6. To develop and assist committees on medical service and public relations originating within the constituent associations and component societies of the American Medical Association.

"In the exercise of its functioins, this Council, with the cooperation of the Board of Trustees, shall utilize the functions and personnel of the Bureau of Legal Medicine and Legislation, the Bureau of Medical Economics and the Department of Public Relations in the Headquarters Office."

The Council is also bound by the actions of the House of Delegates on the subject of medical care and its distribution, notably the platform adopted in 1937 as amended and amplified in subsequent years by the various resolutions and reference committee reports adopted by the House of Delegates.

The central office of the Council is located in the office building of the American Medical Association in Chicago, and is composed of the following to be elected annually: Chairman, Vice-Chairman, and full time secretary. To function adequately the Council must have adequate sources of information and maintain close contact with the constituent associations and component societies. The Bureau of Economics will do the research for the Council in cooperation with the Bureau of Legal Medicine and Legislation and joint bulletins will be issued on legislative matters, with the aim set at a wider distribution and more frequent publication (under the deparment of Public Relations).

The Council has requested that each state association designate an existing committee or create a new committee to function with the Council on a state level, that they may be kept informed of proposed changes in the status of medical care in the various states. Each state association has been requested to contact each component society in order that it may organize to function in connection with the programs of Council, and where it is feasible, it has been suggested that committees be created along the lines of congressional districts.

"State organizations also will be requested from time to time to conduct experiments in the various methods of medical care and to inform the Council of their results so that the Council may study and evaluate the experiments and transmit the information acquired to all concerned."

The Council will inform the profession through the various state organizations of all pending national legislation and bureau directives affecting the practice of medicine. The Council will have representatives at meetings and hearings pertaining to medical care, collaborating in the representation with other Councils and Bureaus of the American Medical Association who have an interest in this same subject.

K.C.U. OF PHYSICIANS AND SURGEONS TO CLOSE

The controversy over the authenticity of the Kansas City University of Physicians and Surgeons which has continued in the newspapers and Jackson County Medical Society Bulletin for some time has finally come to a show down.

The Better Business Bulletin of December 6 has the following to say:

"The Kansas City University of Physicians and Surgeons, long a sore spot in medical education, has agreed to surrender its charter and quit business, June 1, 1944, Dr. James Stewart, state health commissioner, Jefferson City, Mo., has announced. This action by the local school followed a recent editorial in the Jackson County Medical Society Bulletin checking up to the Better Business Bureau or the State Board of Health the status of the school. The editorial closed: 'Who has the guts to find out the real status of the Kansas City University of Physicians and Surgeons, at 2801 Troost?'

BUREAU STARTS INVESTIGATION

"The challenge was accepted and investigation was made by the Bureau and the State Board of Health. A complete written report of Bureau findings was filed with Dr. Stewart who thanked the Bureau, saying: "I . . . wish to congratulate and thank you for such a thorough and splendid report.'

INADEQUATE FACILITIES

"Following receipt of the Bureau report, the Board visited the school, and found its facilities 'wholly inadequate for the teaching and proper instruction of candidates for the degree of doctor of medicine," and recommended a suit by the attorney general to revoke the charter. The school is housed in an old brownstone building, formerly a residence, at 2801 Troost Ave.

"The agreement between the attorneys for the Board and the school reads:

> 'In consideration of the State Board of Health not instituting any proceedings against said corporation, the latter does agree to dissolve on June 1, 1944, by



"Always tired" is a common enough complaint, but when accompanied by markedly low resistance to infections, low muscular tone and vascular weakness, by mental apathy and depression, the cause may be adrenal cortical insufficiency.

ADRENAL CORTEX EXTRACT (UPJOHN) offers potent replacement therapy with which to combat this syndrome. So carefully are the active steroids extracted to make this *natural* complex, so pure is the final cortical extract, that there is practically no trace of epinephrine, the hormone of the adrenal medulla.

Upjohn pioneering and research have resulted in the potent, reliable preparation many physicians use when a characteristic "syndrome of lowness" points to adrenal cortical insufficiency.

Adrenal Cortex Extract (Upjohn)

Sterile solution in 10 cc. rubber-capped vials for subcutaneous, intramuscular and intravenous therapy

Upjohn
KALAMAZOO, MICHIGAN

ANOTHER WAY TO SAVE LIVES . . . BUY WAR BONDS FOR VICTORY

an appropriate legal method and to surrender its charter at that time.'

"In the meantime, the charter will be held in escrow in a Kansas City bank and the school will accept no new students.

OLD CHARTER

"The school, chartered in 1918, is not recognized by the American Medical Association or the Association of American Medical Colleges. Its graduates are not eligible to take the examination for practice in Missouri or any other state with the exception of one or two states including Massachusetts.

"In the 1920's the school sought recognition from the State Board of Health, and when the Board declined to accredit the school, the officers brought certiorari action in the state courts. The Board's decision was sustained. The Missouri Supreme Court later affirmed the ruling of the Board.

OSTEOPATHS ON FACULTY

"Of the faculty listed in the school's latest Bulletin, a number of men with M.D. after their names are licensed in Missouri as osteopaths only. It was also found that graduates of osteopathic schools are given credit for three years standing, and are required to put in only one year of residence work. School officials also admitted in instances giving full credit to students who have been dropped from other medical schools.

'The school has for many years been the subject of inquiries or complaints from students who claimed their enrollments were secured through misrepresentations and deception, some claiming they had traveled from distant states to attend the school, and learned only after enrolling that they would not be allowed to take state board examinations.

"The State Board of Health and its members should be commended for their vigorous stand against this school, which has utilized an old state charter to confer M.D. degrees, despite the ban upon their graduates from even taking the examination for the practice of medicine."

KANSAS DOCTOR SHORTAGE

The Kansas situation on doctors again drew the limelight when Dr. Thomas Parran, Surgeon General of the United States Public Health Service made the recent announcement that certain communities in the state were desperately in need of doctors of medicine. He based his statement on a survey made on September 15.

Kansas as a state and Kansans as a people have a particular faculty for making newspaper headlines, whether it be Carrie Nation and her hatchet, Alf Landon for President, the bumper wheat crop, our surplus of oil and gas with the present status of rationing, or now the doctor-shortage scare.

We have been informed by Dr. F. L. Loveland, state chairman for the Procurement and Assignment of Physicians, that the towns of Lebo, Spearville, Neodesha and Eudora, mentioned in the report, are situated as follows at the present time: two new docors have located in Neodesha, Dodge City doctors are taking care of Spearville patients, and Lebo is being taken care of by a physician from Osage City. Eudora, a "war production mushroom town," has a trailer town adjacent, which will necessitate considerable additional work for the physicians of that and adjoining communities during the winter months. The working population of Eudora has access to the hospital and staff of the well equipped Eudora war plant. Eudora is, however, being well taken care of at the present time.

Kansas has contributed a large number of physicians to the armed forces and as a result all of the doctors in the state are giving longer and longer hours to patients. Many of the previously retired physicians are going back or have gone into partial practice to help on the home front. A few doctors have recently come into Kansas from other states, and several Kansas physicians have volunteered to be moved to communities where a shortage is reported. Unfortunately for the program some long established physicians have chosen this time to move to larger communities already reasonably well cared for and have thereby created new problems of relocation.

Kansas has had a great population shift to the centers of war industry and war training which has necessitated a constant vigil on the part of the committee handling the situation.

A.M.A. MEETING EXHIBITS

The Scientific Exhibit at the Chicago Session of the American Medical Association, June 12-16, 1944, will be held at the Palmer House. Exhibits will cover all phases of medicine and the medical sciences with particular emphasis on graduate medical instruction for the physician in general practice.

Applicaion blanks for space in the Scientific Exhibit are now available and may be obtained by communicating with the Director, Scientific Exhibit, American Medical Association, 535 N. Dearborn Street, Chicago 10, Illinois.

DR. VERNE C. HUNT SHOT

Recent word has been received in the office of the death of Dr. Verne C. Hunt of Los Angeles, California. Dr. Hunt was shot by a man identified as Ephram Mousey, who later committed suicide.

Dr. Hunt is well known to many Kansas physicians, as a former member of the staff of the Mayo Clinic, who later moved to California to enter private practice. He was a speaker at the meeting of the Western Surgical Association held in Topeka in 1940. Dr. Hunt was the clinical professor of surgery of the University of Southern California School of Medicine.

KANSAS X-RAY TECHNICIANS SOCIETY APPROVED

Information has recently been received that the Kansas Society for X-Ray Technicians has been affiliated with the American Society of X-Ray Technicians by recent action of the Board of Chancellors of the American College of Radiology. A committee appointed by the Board will act in an advisory capacity, and the appointment of this committee constitutes official recognition of the Kansas Society by organized radiology.

The officers of the Kansas Society for X-Ray Technicians are as follows: President, Miss Sophia McQuillan, R. T. of Clay Center (Municipal Hospital); Vice-President, Mrs. Cora McJrlton, R. T., Newton (Axtell Clinic Hospital); and Secretary-Treasurer, Mrs. Nevin Cornwell, R. T., Manhattan (615 N. Juliette Street).

The Kansas Society of X-Ray Technicians is making plans for a convention to be held in Topeka at the Hotel Jayhawk the last week of March, 1944, and according to

In the "Chronic Fatigue" of Mild Depression



After employing Benzedrine Sulfate therapy in a series of 40 patients diagnosed as suffering from nervous exhaustion, Nathanson concludes:

"In approximately 80 percent of the patients there was a marked amelioration of this symptom (fatigue). Many of the patients had complained of fatigue for long periods and had tried various types of treatment without benefit . . .

"A sense of increased energy and capacity for work was noted in more than half of the cases. In addition a feeling of exhilaration and sense of well being was a consistent effect . . . Many patients volunteered that there had been a definite increase in mental activity and efficiency." Nathanson, M. H.—J. A. M. A., 108:528, 1937.

Benzedrine Sulfate Tablets

Brand of racemic amphetamine sulfate

Benzedrine Sulfate is primarily useful in depressions characterized by apathy and psychomotor retardation, but is contraindicated in patients manifesting anxiety, hyperexcitability, or restlessness.

The use of Benzedrine Sulfate by normals should not be permitted; it should always be administered under the careful supervision of a physician; and depressive psychopathic cases should be institutionalized.

In treating depressed patients with Benzedrine Sulfate, the physician should bear in mind that any drug which produces pleasant or euphoric effects may prove to be habit forming—especially in unstable or neurotic individuals

SMITH, KLINE & FRENCH LABORATORIES
PHILADELPHIA, PA.

word from Miss Sophia McQuillan, the President, it is hoped that all x-ray technicians in the state will avail themselves of the opportunity to be present at the convention.

PORTER LECTURESHIP

The University of Kansas School of Medicine held the thirteenth annual Porter Lectureship on December 8 and 9 at Kansas Ciy and Lawrence. This year's speaker was Dr. Herbert M. Evans, Director of the Institute of Experimental Biology of the University of California at Berkley, California.

The schedule of lectures was as follows:

Wednesday, December 8—8:00 p.m.—Kansas City "The Present Position of our Knowledge of the Anterior Hypophyseal Hormones."

Thursday, December 9—10:30 a.m.—Lawrence "The Internal Secretions of the Pituitary Body; A Historical Resume."

Thursday, December 9—8:00 p.m.—Kansas City "The Adrenotropic Hormone of the Anterior Hypophysis."

The lectures in Kansas City were given in the Children's Pavilion of the University of Kansas Hospitals and those at Lawrence were given in the Fraser Theatre.

Dr. J. D. Porter of Paola in 1918, bequeathed to the Universiy of Kansas School of Medicine a sum of money for the stimulation of scholarship and research in the medical field, and a portion of this money is used annually for the lectureship. The remainder of the fund is used to provide scholarships for worthy students.

RESIGNATION

Dr. Fred Mayes, director of the Division of Maternal and Child Welfare of the Kansas State Board of Health has resigned his position on that board as of December 1, 1943, to accept a position as Regional Medical Consultant for the Children's Bureau at Washington, D. C. At the present time Dr. Mayes is located in the Kansas City district but it is not known where he will be stationed permanently.

Dr. Mayes was graduated from the University of Kansas School of Medicine in 1938 and interned at the Henry Ford Hospital in Detroit, Michigan, after which time he was employed as Medical Director of the four county District, comprising the counties of Gove, Graham, Sheridan and Trego with offices at Quinter. On May 1, 1942, he was appointed as Director of the Division of Maternal and Child Welfare of the Board of Health in Topeka and has been instrumental in setting up the program for Service Men's Dependents. Dr. Mayes is to be congratulated on his step upward in the same field which he organized so successfully in the state.

COUNTY SOCIETIES

At a meeting of the Leavenworth County Medical Society which was held on December 6 the following were elected to office: Dr. D. R. Sterett as President; Dr. C. A. Bennett as Vice-President; and Dr. J. T. Anderson as Secretary-Treasurer.

A meeting of the Lyon County Medical Society was held in Emporia on December 7. Dr. Frank Foncannon of Emporia presented a paper on "New Developments in Surgery" and showed a movie on "Splints, Varicose Veins and Hysterectomy." The following new officers were elected: Dr. C. W. Lawrence as President; Dr. C. J. Corbett as Vice-President; Dr. C. H. Munger as Secretary-Treasurer. Dr. F. A. Eckdall, Dr. H. C. Nutting and Dr. Frank Foncannon were elected as members of the Board of Censors, with Dr. O. J. Corbett elected as Delegates and Dr. Paul Trimble and Dr. W. B. Granger as Alternates.

At the December 7 meeting of the Sedgwick County Medical Society Dr. George A. Walker of Kansas City presented a paper on "The Pathology of Hypertension." At the November 2 meeting of the Society Dr. W. Kenneth Jennings of Pittsfield, Illinois, discussed "Diagnosis and Treatment of Carcinoma of the Recum" which he illustrated with motion pictures.

DEATH NOTICES

CORRECTION—Dr. Charles R. Nelson, 65 years of age, died on October 18 at his home in Jamestown. He was graduated from the Kansas City Medical College in 1904 and practiced in Jamestown and Concordia. He was an honorary member of the Cloud County Medical Society.

Dr. Thomas Oscar Brown, 74 years of age, died on November 12 after an extended illness. He had been a resident of Osage City for many years. He was graduated from the University Medical College of Kansas City in 1897 and was a member of the Osage County Medical Society.

Dr. Robert J. Morton, 86 years of age, died on December 3 at his home in Clay Center. He was graduated from the University of Illinois College of Medicine in 1883 and was an honorary member of the Clay County Medical Society.

MEMBERS

Dr. S. M. Hibbard formerly located at Sabetha has moved to Topeka where he has opened an office.

Dr. J. J. Tretbar of Stafford is now located at Takoma Park, Maryland.

Dr. George M. Gray of Kansas City, Treasurer of the Kansas Medical Society, has announced his retirement after sixty-three years of medical service. Dr. Gray is at home again after a prolonged stay in the hospital due to a fall that resulted in a fractured right hip, a fractured wrist and several broken rib.

Dr. L. K. Chont of Norton has recently moved to Winfield, where he has opened offices in the First National Bank Building.

Dr. A. H. Bressler, formerly of Manhattan, has recently completed a refresher course and opened offices in Wamego. Dr. Bressler has been retired for the past few years.

Dr. Jerome E. Andes, Dr. John F. McDonnell and Dr. D. A. Wallace of Lawrence are the co-authors of an article

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2—149-154.

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in the December 4 issue of the Journal of the American Medical Association, entitled "Nail Puncture Wounds."

Dr. T. T. Myers of Marysville has begun a surgical fellowship at the Mayo Clinic in Rochester, Minnesota, and left Marysville on November 1.

Dr. E. T. Heckart of Carbondale has opened an office in Topeka and will be in the Carbondale office part time also. Dr. Heckert recently completed post graduate work at the Cook County Hospital in Chicago, Illinois.

Dr. J. D. Hinkle of Baxter Springs has recently moved to Ness City.

Dr. Arthur E. Hertzler of Halstead is the author of an article entiled "Local Anesthesia, A. Requiem" which was published in the September-October issue of Current Researches in Anesthesia and Analgesia.

Dr. A. L. Spafford of Parker and Osawatomie has moved to Kansas City, Missouri.

Dr. J. R. Rupp has recently returned to Liberal after completing post graduate work in surgery at the Mayo Clinic in Rochester, Minnesota.

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AMERICAN PHARMACEUTICAL ASSOCIATION GIVES THREE TONS OF QUININE TO ARMED FORCES

According to a recent report the American Pharmaceutical Association gave 9,000,000 doses of five grains each, or more than three tons of quinine to the armed forces. The collection of quinine from American druggists began on February 15 and the gift was received on behalf of the Army and the Navy by Chairman May of the Military Affairs Committee and Admiral Ross T. McIntire, Surgeon General of the Navy.

The original story which was carried in the Washington, D. C., Evening Star, reports that the quinine is to be reprocessed in the navy laboratories and made immediately available to the men in service. The market value of the quinine collected is said to be about $88,500.

FOOD FOR OVERSEAS FORCES

The many problems of feeding the overseas troops of the United States are being successfully solved by the Quartermaster's Subsistence Research Laboratory, whose job is to make Army rations palatable and nutritious under adverse conditions of transportation and storage.

Four different types of field rations have been developed, known as Rations A, B, C, and D. Field Ration A is composed of both perishable and nonperishable foods, purchased, in part, in the area where the troops are stationed. In restricted areas troops are given Ration B, which is made up of sugar, salt, flour, and canned or dehydrated meats, fruits, and vegetables.

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are issued. Ration C, consisting of 6 cans of food, is the chief operational ration. Three of the cans, one for each meal, are identical—containing hard candy, special biscuits, sugar, and soluble coffee. The other three contain meat and beans, meat and vegetables, and meat and vegetable hash. Ration D, an emergency ration, is composed of three four-ounce chocolate bars, reinforced with thiamine.

Another ration, designed for parachute troops, may replace Ration C. This is called Ration K and includes three moisture-proof and gas-resistant packages, each containing two kinds of biscuit, canned meat or cheese, a confection, a beverage concentrate, chewing gum, and four cigarettes.—New York State Journal of Medicine.

RATIONING FOR PATIENTS

The office of War Information Price Administration of Washington, D. C., has released the following information in regard to hospital problem in food rationing:

"While the wartime need of conserving rationed foods is great, no hospital patient need suffer from inability to get foods required for his health.

"The OPA is sending specific instruction highlighting this point to all local War Price and Rationing Boards and to other OPA field offices. For several months, OPA and medical authorities have been studying the hospital problem with a view to developing a uniform procedure covering the granting of supplemental allotments for hospitals. Solution of the problem is believed near.

"In the meantime,—OPA said—a provision in the regulations (Section 11.6 of General Ration Order 5) should enable hospitals to obtain the necessary supplemental allotments so that no patients shall suffer from dietary deficiency. This provision given local boards authority to grant such allotments to meet the dietary requirements of patients living in, and receiving care in, hospitals, whether or not such patients are on special diets.

"In determining the amount of the supplemental allotment of processed foods and the commodities covered by Ration Order 16, the local board will take into consideration the availability of fresh fruits and vegetables, unrationed substitutions such as poultry and fresh fish, and the physical facilities of hospitals to process and store such foods.

"Administrative officers of hospitals had complained that local boards in some cases had confined the granting of supplemental allotments to situations covering patients on special diets.

"Section 11.6 of the ration order does not limit the granting of relief so narrowly, OPA explained. No hospital patient need suffer from inability to get food because of rationing."

AN IMPORTANT COMMUNICATION FROM OFFICE OF CENSORSHIP

The following statement appears in The Journal of the American Medical Association for June 19:

"A letter from the Office of Censorship in Washington requests the editor of The Journal to call the attention of editors of state medical journals and of the bulletins of county medical societies particularly and also editors of all other medical publications to the fact that it is exceedingly inadvisable to publish uncensored letters coming from doc-



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tors in the service, particularly when they include the addresses of the physicians. Already in several instances such letters have served to reveal the identity of troops overseas. The Code of Wartime Practices for the American Press calls attention to the great danger that is inherent in this practice.

"All publications are particularly requested to avoid identification of soldiers with their troop units when they are overseas, about to embark or on defense (as distinguished from training) activities in the United States. In the case of Naval personnel the identification of ships and bases is to be especially avoided. Editors of all publications will, we are sure, do their utmost to cooperate with the Office of Censorship in Washington, since the revealing of units to which physicians are attached may be of great value to the enemy in determining the character of the armed force with which it has to deal. When in doubt, editors will do well to get a direct response from the Office of Censorship regarding the release of any special item."

It has been estimated officially that at least two-thirds of the 80,900 doctors under forty-five years of age will be required by the Army and Navy. That is nearly one-third of America's total medical force.—The Pennsylvania Medical Journal.

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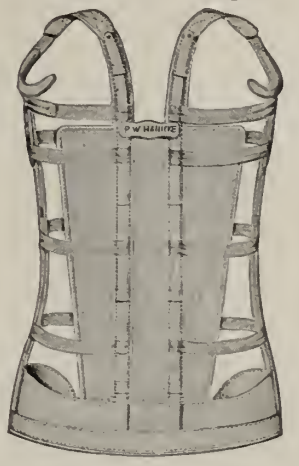
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BOOKS REVIEWED

ATLAS OF OBSTETRIC TECHNIC—Paul Titus, M. D., Illustrations by E. M. Shackelford. Published by C. V. Mosby Company, of St. Louis, Missouri. Price $7.00. This book is a brief, 178 page illustrated outline of essential points in obstetrical procedures. Outlines and descriptions accompany the 193 illustrations and space is provided following each of the fifteen sections for additional personal notations.

Many procedures and operations are very well pictured in detail, showing refinements in technic with helpful suggestions in the text matter not easily found elsewhere. The pictures are remarkable for their clarity and prominence of the point emphasized. A few sections are, perhaps, too briefly outlined so that the book should supplement, rather than displace, larger texts.

Every physician with an obstetrical practice will find this book a helpful adjunct in refreshing his knowledge of up-to-date obstetrical office and hospital procedures. — R. E. P.

HUGHES' PRACTICE OF MEDICINE, Sixteenth Edition, Revised and edited by Burgess Gordon, M. D., Clinical Professor of Medicine, Jefferson Medical College. Published by the Blakiston Company of Philadelphia, Pennsylvania and priced at $5.75. The volume contains 791 pages and the chapters include the following subjects: infectious diseases, due to bacteria; virus infections, diseases due to rickettsiae, mycotic infections, diseases due to protoza; diseases due to spirochetes, disease due to metazoa, diseases of doubtful etiology, diseases of allergy, diseases due to physical agents, the intoxications, diseases due to chemical agents, deficiency diseases, diseases of the locomotor system, diseases of the bones, diseases of metabolism, diseases of the digestive system, diseases of the liver, diseases of the bile passages and gall bladder, diseases of the pan-

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BOOKS RECEIVED

Announcement has been received from E. R. Squibb and Sons of New York that a Monograph has been published and is available to physicians and public health officers gratis and to medical libraries on the subject of Lymphogranuloma Venereum." The detection and differential diagnosis of lymphogranuloma venereum were made by Rake, McKee and Shaffer, who have cultivated the agent in the yolk sac of the embryonated chicken's egg and obtained concentrated suspensions of elementary bodies and in this manner a highly purified and specific antigen, known



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KANSAS MEDICAL ASSISTANTS SOCIETY

The Lyon County Medical Assistants Society held its Christmas dinner on December 7 at the home of Miss Irene Miller in Emporia. Dispensing with the usual Christmas gift exchange, the society decided to make individual donations to some one project in the name of the organization during the holiday season. The next meeting is scheduled for January 4, 1944.

The Cowley County Medical Assistants Society held a meeting on November 18 at the home of Miss Mary Nicholson in Winfield. Miss Emmeline Moore, demonstrated the Kenny method of treatment for infantile paralysis.

The Shawnee County Medical Assistants Society held a Christmas party at the Menninger Clinic on December 6. Miss Esther Conors was in charge of the entertainment for the party. Canned goods and staples were brought by each member attending and are to be given to a needy family for Christmas.

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AUXILIARY

PRESIDENT'S MESSAGE

I am very happy to tell the Auxiliaries that our National President, Mrs. Eben J. Carey of Wauwatosa, Wisconsin, plans to visit us during our state meeting. Mrs. Carey said she especially wished to visit Kansas.

The National Board of Directors met in Chicago on November 19. Emphasis was placed upon getting students to take up nursing and the procuring of nurses for war service. Every Auxiliary is urged to have these as its main objectives. It is necessary for us to do this as we must have more nurses. The luncheon meeting was devoted almost entirely to these projects. Representatives of the United States Cadet Nurse Corps and Procurement and Assignment Commission explained these two projects which the National Advisory Council of the American Medical Association has asked us to assume. The date for nation-wide registration of all nurses is the week of February 8. All Auxiliaries are asked to help with this work as there are three cards to be made out for each nurse and requires a great deal of writing. Dr. Ralph Fenton, member of the Advisory Council of the American Medical Association, spoke briefly of this work and also warned us as doctor's wives to watch our affiliations. Dr. Herman L. Kretschmer, President-Elect of the American Medical Association, also spoke of student nurses. He advised the girl to go to a big institution in a big town; if not in a big town at least a big institution. He also advocated two subscriptions to Hygeia by every doctor and to tell every patient about the Wagner-Murray-Dingell Bill.

Many organizations have a membership month and put on an intensive drive for new members during that time. Would you like our Auxiliary to choose a certain month for all the members to cooperate in a special effort to get all eligible members to join during that month? It might solve the problem of getting the dues in on time if the time of the month chosen was early in the fall. At least think it over.

The radio program "Doctors at Work" will be on the air at 4:00 p.m. starting January 8.

Since it is not possible for the Natioinal Hygeia Chairman to contact each county chairman personally her instructions are in the Hygeia handbook. If Hygeia Chairmen will read over this little book I feel they will be very enthusiastic about getting subscriptions for Hygeia. One of the goals presented at the National Board Meeting was two Hygeia subscriptions by every doctor. One for the office; the other for the home. In one Cook County Auxiliary every member subscribes to Hygeia and are pledged to send ten as Christmas presents.

The National Legislative Chairman thinks that the Wagner-Murray-Dingell Bill will not be passed at this time, but will appear again soon in another form so we must be ever vigilant. In many states the Auxiliaries have been busy writing letters to their congressmen and representatives so that their mail has been flooded with sentiment against the bill. If you have not already writen please study the bill so that you will impress the legislator with factual knowledge of what the bill contains when you write.

I met with our President-Elect, Mrs. Leo Schaefer and her Auxiliary at a luncheon meeting on December 9, in Salina. They have a very active organization, all doing some kind of war work.

Do not forget to send to Mrs. H. L. Regier any change of address of any member and all news items to Mrs. Earl R. Millis.

Sincerely,

Mrs. E. E. Tippin.

AUXILIARY NEWS

The Women's Auxiliary to the Shawnee County Medical Society held a dessert luncheon at the home of Mrs. J. F. Casto in Topeka on November 8. Assisting hostesses were Mrs. G. W. B. Beverly and Mrs. R. W. Emerson. Judge Roy McCue gave a talk on "Juvenile Delinquency."

The November 8 meeting of the Women's Auxiliary to the Sedgwick County Medical Society was held at the Red Cross offices in Wichita, where the members rolled bandages in the morning and later a luncheon was served by the Canteen girls of the Red Cross. A business meeting was held and was followed by a discussion of the Wagner-Murray-Dingell Bill. The December meeting will also be held at the Red Cross rooms.

The Women's Auxiliary to the Wyandotte County Medical Society held its Christmas tea at the home of Mrs. John A. Billingsley in Kansas City, at which the wives of physicians in service were the guests of honor. Christmas stories and Christmas carols formed the entertainment. Assisting hostesses were: Mrs. K. C. Haas, Mrs. Galen Tice, Mrs. Albert Huber, Mrs. F. S. Carey, Mrs. J. E. Barker, Mrs. Hughes Day, Mrs. LaVerne B. Spake, Mrs. Donald Medearis, Mrs. J. F. Hassig, Mrs. Clarence Weber, Mrs. A. J. Rettenmaier, Mrs. E. J. Grosdidier, Mrs. W. J. Feehan and Mrs. Merle Parrish. Mrs. E. D. Williams has been appointed War Chairman for the year.

THE MEANING OF MEMBERSHIP

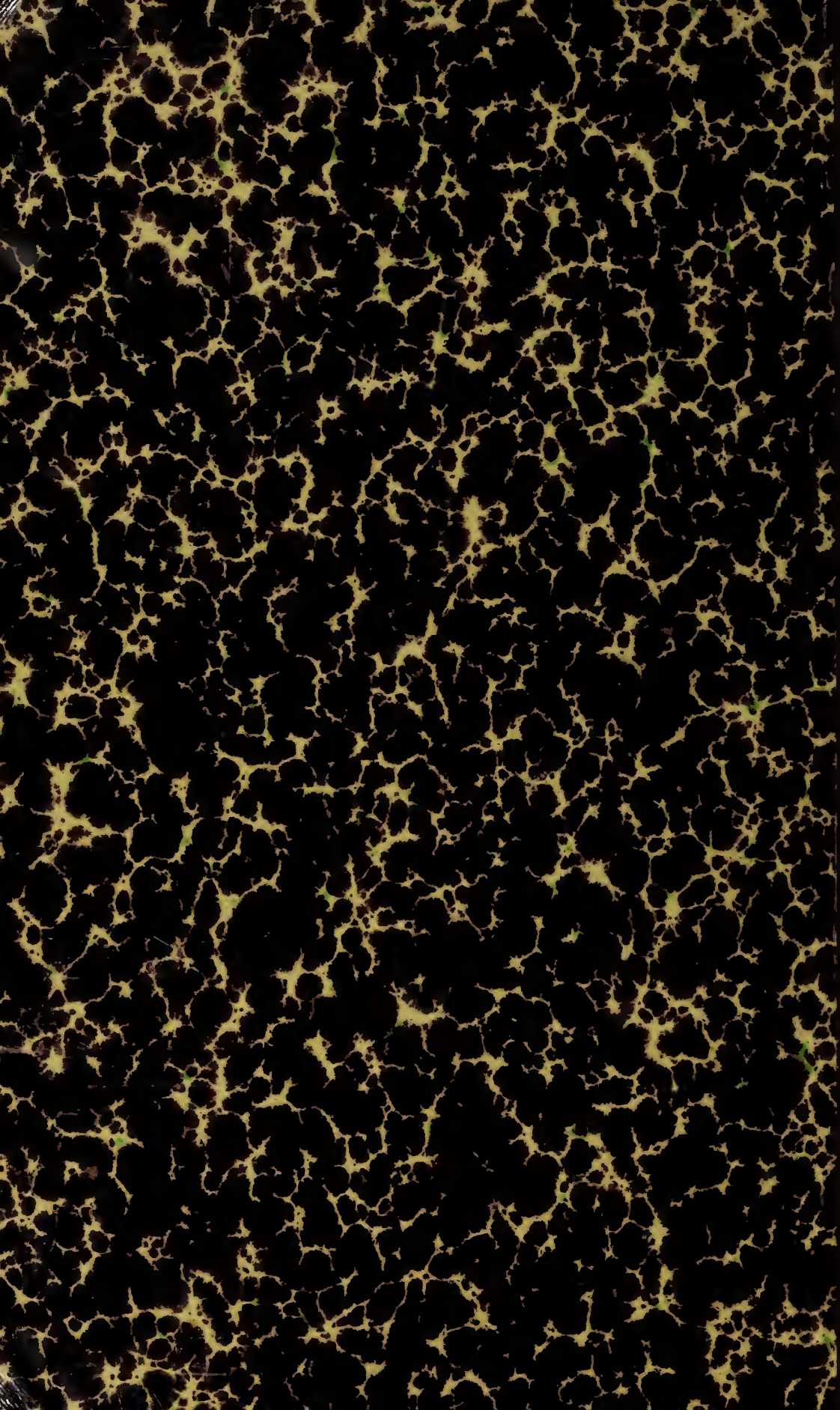
Today men and women in the armed forces, and the civilians at home, are fighting and working to defend and preserve "our way of life."

Our doctors of medicine have been fighting for "our way of life" since 1540 A.D., at which date in history the early schools of medicine arose.

"Our way of life" means preventive medicine, sanitation, good housing, prenatal care, nutrition, and we could go on and on.

All energy today is directed toward victory over our vicious foes in war. As members of an auxiliary to the profession of doctors of medicine, we may think of victory in connection with that profession. Our doctors of medicine have been victors in their war on disease that threatens mankind, and many have given their lives in attending to their professional duties, as for instance in contagious diseases. Victory is theirs in insulin, in the treatment of diabetes, in the use of sulfa drugs, and in the thousand and one modalities of twentieth century medicine for the prevention, control, and treatment of human disability.

May I urge you to exercise your privilege of membership in an auxiliary of this noble profession.—Pennsylvania Medical Journal.



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